

**The TEHIP 'Spark':
Planning and Managing Health Resources
At the District Level**

A Report on TEHIP and its Influence on Public Policy

FINAL REPORT

1 April 2004

Stephanie Neilson
and
Terry Smutylo

Evaluation Unit, IDRC

Executive Summary

Beginning in 2001, IDRC's Evaluation Unit carried out a strategic evaluation to observe whether or not the research it supports in the South influences public policy and decision-making, and if so how does it do this. As part of this strategic evaluation, 25 field studies were conducted covering the range of research areas and geographic areas within the Centre's programming. The case study presented here is one of these studies.

The Tanzanian Essential Health Interventions Project (TEHIP) started in 1996 as a four-year research and development project designed to test the feasibility and measure the impact of an evidence-based approach to health planning at the district level. From its inception, through to the development and implementation of the tools, TEHIP was designed to influence health policies at the local and national levels. The project was both timely and relevant since it supported and coincided with the decentralization component of Tanzania's health sector reform movement.

TEHIP developed and implemented several tools for district level health planning. A method for calculating and presenting Burden of Disease data (the BoD tool) and district health accounting were developed to help policy makers better understand the effects of the burden of disease in their respective districts, to allocate resources based on the burden of disease, and to manage and track those allocations. Another tool, the Cascade System, evolved after the project was started in order to organize and integrate health service delivery at the district level more efficiently and economically.

Using a framework for analysis developed for this strategic evaluation, findings in this case study suggest that TEHIP has influenced health policies by expanding policy capacities, broadening policy horizons and affecting policy regimes. TEHIP's work with the district health services in both Morogoro-Rural and Rufiji was seen as having influenced the thinking and actions affecting how research data and other kinds of evidence can be used to make decisions about health policies, programs and priorities. This influence occurred both in terms of (1) **the processes** of policy formulation, implementation and reform; and (2) **the content** of the policies, programs and reforms.

Some of the factors that appeared to have facilitated these influences include: political commitment from senior level officials at both the national and district levels, the collaborative efforts between IDRC and the government of Tanzania and the additional resources TEHIP provided to the districts, that TEHIP was designed and implemented with the intent to work within the existing health planning and management systems, rather than creating a parallel system, and the commitment, dedication and expertise supplied by the TEHIP personnel.

There were also factors that were seen as constraining or inhibiting TEHIP's influence, or potential future influence. These factors include: the "experimental" nature of TEHIP, the existing capacity in the remaining 112 districts to implement the tools on a national scale, limited dissemination of the tools and the results, and the strained relations between TEHIP and AMMP.

Although TEHIP was seen as having made significant contributions to both the processes of and changes to policies, programs and priorities, the challenge to sustaining this influence are numerable. Among other things, this study illustrates the paradoxical nature of "successful projects: then what"? A key question for both donors and governments of developing countries to consider in the future is: how to expand externally funded, district-level support projects to a national scale?

Table of Contents

LIST OF ABBREVIATIONS.....	5
INTRODUCTION AND METHODOLOGY	7
I. Introduction:.....	7
Document Review	8
Interviews	8
Analysis and Validation.....	9
CONTEXT	12
I. Health Sector Reforms:.....	12
II. World Development Report 1993:.....	13
III. The Opportunity – TEHIP:	13
THE PROJECT	15
I. Project Goal and Objectives:.....	15
II. The Policy Intent:.....	16
III. The Project Outputs – The TEHIP Toolbox:.....	17
District Burden of Disease Profile:	18
District Health Accounts:.....	18
District Integrated Management Cascade:.....	18
Community Ownership of Health Facilities	19
District Simulated Basket Funding	19
THE TEHIP INFLUENCE	20
I. Processes.....	20
Burden of Disease and Resource Allocation Tools:.....	20
Simulated Basket Funding.....	22
Community Participation and Ownership of Health Facilities.....	23
Cascade System	24
TEHIP Processes and Policy Influence:	25
II. Content:	26
Guidelines for District Health Plans and the NSS	26
National Focus on Malaria Programs, Anti-malarial Drug Policy and ITNs	26
Essential Health Minimum Package	28
TEHIP's Influence on the National Research System.....	28
TYPES OF INFLUENCE.....	30
I. Expanding policy capacities	30
II. Broadening policy Horizons	32
III. Affecting policy regimes	33
FACTORS OF POLICY INFLUENCE	34
I. Factors that Enabled Influence:	34
Political Commitment:	34
The Collaborative Efforts and Resources Provided:	35
Working Within the Existing System:	35
TEHIP Competencies:	36
II. Factors that Constrained Influence:.....	36
The 'Experimental' Nature of TEHIP:.....	36
Capacity on the Ground:.....	37
Limited Dissemination (as seen by others):	37
TEHIP and AMMP:	38
TEHIP IN HEALTH POLICY	40
I. Research to Policy Linkages in Tanzania:.....	40
II. Type and Use of Research in TEHIP	41
CONCLUDING REMARKS.....	44
The Challenge to Sustaining the TEHIP Influence:.....	44

APPENDIX 1: TERMS OF REFERENCE	46
APPENDIX 2: LIST OF INTERVIEW QUESTIONS.....	52
APPENDIX 3: LIST OF INTERVIEWEES:.....	55
APPENDIX 4: TOMBSTONE DATA.....	63
REFERENCES	64

List of Abbreviations

AMMP	Adult Morbidity and Mortality Project
BoD	Burden of Disease
CIDA	Canadian International Development Agency
CHMTs	Council Health Management Teams
CMO	Chief Medical Officer
DED	District Executive Director
DfID	Department for International Development (UK)
DMO	District Medical Officer
DSS	Demographic Surveillance System
EHIP	Essential Health Interventions Project
GoT	Government of Tanzania
HMIS	Health Management Information Systems
HSR	Health Sector Reforms
IAC	International Advisory Committee
IDRC	International Development Research Centre
ITN	Insecticide Treated Nets
IMCI	Integrated Management of Childhood Illnesses
NIMR	National Institute of Medical Research
NMCP	National Malaria Control Programme
NSS	National Sentinel Surveillance System
MARA	Mapping Malaria Risk in Africa
MOH	Ministry of Health (central government)
PSI	Population Services International
RDSS	Rufiji Demographic Surveillance System
SWAp	Sector Wide Approach
TEHIP	Tanzanian Essential Health Interventions Project

UNICEF	United Nations Fund for Children
USAID	US Agency for International Development
WDR	World Development Report
WHO	World Health Organization

Chapter I

Introduction and Methodology

Kupaanga ni Kuchagua – To plan is to choose
Julius Nyerere

I. Introduction:

The interrelated questions of whether and how research influences public policy and decision-making has long been debated in the social sciences. Several international donors and development agencies have recently returned to these questions in earnest. For donors, responding to these questions contributes to the larger question of how aid for development programming effects public policies in the South, and what strategies achieve what results. Over the past 30 years of supporting research in the South, the International Development Research Centre (IDRC) has gained considerable experience in fostering research-policy links. Nevertheless, as of 2000, IDRC had not yet developed a systematic, corporate understanding of its successes, limitations, and the factors that contribute to or inhibit policy influence. Beginning in 2001, IDRC's Evaluation Unit carried out a strategic evaluation to observe whether or not the research it supports in the South influences public policy and decision-making, and if so how does it does this. The study started with three key questions:

1. What constitutes policy influence in IDRC's experience?
2. To what degree and in what ways has IDRC-supported research influenced public policy?
3. What factors and conditions have facilitated or inhibited the public policy influence potential of IDRC-supported research projects?

The findings were intended to serve two main purposes: (1) to provide learning at the program level to enhance the design of projects and programs to increase policy influence where this was a key objective; and (2) to create an opportunity for corporate level learning which would provide input into strategic planning processes as well as feedback on performance.

As part of this strategic evaluation, 25 field studies were conducted covering the range of research areas and geographic areas within the Centre's programming. The case study presented here is one of these studies. Designed as a learning exercise for IDRC staff and partners, this strategic evaluation served to foster learning in various ways including: lessons distilled from the background studies and cases; through the engagement of staff and partners in the analysis and interpretation of the data; and through various dissemination fora and publications.

The Tanzanian Essential Health Interventions Project (TEHIP) started in 1996 as a four-year research and development project designed to test the feasibility and measure the impact of an evidence-based approach to health planning at the rural district level. From its inception, through to the development and implementation of the tools, TEHIP was designed to influence health policies at the local level. The project was both timely and relevant since it supported and coincided with the decentralization component of Tanzania's health sector reform movement.

Developed in partnership with the Government of Tanzania, and with substantial funding from the Canadian International Development Agency (CIDA), TEHIP engaged in health services planning, policy and management initially at the district level, and eventually at the national, regional and international levels. From the start, TEHIP was considered a "unique" project for IDRC in that it was not a "typical" research project since it had the administrative and financial support (CAD\$20 million) to take the research findings into the next stage of development.

II. Approach and Methodology:

In accordance with the terms of reference provided for each of the cases within the strategic evaluation, a case study approach was used to develop rich descriptions that explore both the strategies undertaken and the changing contexts in which the work was carried out. Because our intent was to understand how research influences policy, TEHIP was deliberately selected as a case where program staff felt policy influence had occurred.

Data was collected around three basic questions: what happened, how did it happen and why?¹ The data were collected primarily through document review and face-to-face interviews with key informants. This data were then analyzed using a framework developed specifically for these case studies.

Document Review

A desk study to review documents was completed before the researchers arrived in the field. These documents included: IDRC Project Approval Document, Annual Reports, progress reports, trip reports, evaluation reports, meeting minutes, and various dissemination materials (e.g., TEHIP Newsletters, briefing notes, presentation materials). This review yielded an understanding of TEHIP's intentions and a chronological history of the project from its inception. It also provided the initial identification of key informants for interviewing.

Interviews

Using a structured yet flexible interview guide, 42 in-depth interviews with 51 respondents were conducted in Tanzania by two Canadian evaluators (Evaluation Unit staff) between September 21 and October 8, 2002². For the most part, the interviews were conducted on an individual basis; however, there were three instances when group interviews were considered more appropriate or feasible³. The interviews were semi-structured in nature and lasted from between 45-90 minutes in length. The flexible structure allowed conversations to flow freely into the areas in which interviewees were most knowledgeable and willing to go. This helped to deepen the inquiry and understanding of the discussion.

Key informants were selected on the basis of (1) their knowledge of TEHIP; (2) their knowledge of the project outputs; and/or (3) their knowledge of the Tanzanian health sector. Informants for this case study included:

- ❑ TEHIP project staff;
- ❑ Researchers working for national research institutions such as the National Institute for Medical Research (NIMR), Ifikara Research Centre, and the Institute of Public Health (Muhimbili University College of Health Science, University of Dar es Salaam);
- ❑ Senior level Ministry of Health officials at the national level including the Permanent Secretary, the Chief Medical Officer, the Director of Policy and Planning, the Head of the Health Sector Reform Secretariat, the Director of Preventive Services, and the Acting Director of Human Resources Development;
- ❑ Senior level government officials at the district level for both Morogoro-Rural and Rufiji Districts including the District Executive Director (DED), District Medical Officer (DMO); and members of the Council Health Management Teams (CHMTs);
- ❑ Project and program staff from other international donor agencies including UNICEF, DfID, the World Health Organisation (WHO), the World Bank, USAID, and Population Services International (PSI); Royal Netherlands Embassy;

¹ For a complete version of the Terms of Reference see Appendix 1.

² See Appendix 2 for an example of some of the questions used in the interviews. It is important to note that similar questions were used but approached differently depending on whether or not the respondent perceived himself or herself as a policy maker, a researcher, another donor, or policy implementer.

³ For a complete list of the interview schedule see Appendix 3.

- ❑ Project and program staff from Tanzanian government and non-government agencies and programs such as Tanzanian Public Health Association, National Malaria Control Programme (NMCP), and the Centre for Education Development in Health (CEDHA).

With the consent of all respondents, the interviews were recorded to ensure that data collected could be verified as accurate in representing respondents' views and impressions about TEHIP.

Analysis and Validation

Data collected were coded and analysed by the two researchers. Triangulation of interviews and documents was used to validate the analysis and interpretations of respondents' views and perceptions of TEHIP's influence on policy.

For coding purposes, the respondents were categorised as:

1. Policy and decisions makers
2. Researchers
3. Other donors
- 4a. Policy implementers (national level)
- 4b. Policy implementers (local level)

Of the 42 interviews (N=42) 12% were conducted with policy and decision makers, 21% were researchers, 29% were conducted with other donors, 17% were conducted with national level policy implementers and 21% were with district level policy implementers (see Box1).

Box 1: Frequency of Categories

Category	Count (N=)	Proportion (%)
1. Policy and decision-makers	5	12
2. Researchers	9	21
3. Other donors	12	29
4a. National level policy implementers	7	17
4b. District level policy implementers	9	21
Total	42	100

Categorizing the respondents allowed for their differing perspectives and points of view to be brought into the analysis and interpretation of the data. It also enabled verification of coverage of all groups either directly or indirectly affected by TEHIP and/or its outputs. This report is a synthesis of the findings from the analysis.

Framework for Analysis: Types of Policy Influence

For the purpose of this study, a framework for analysis developed by Evert A. Lindquist⁴ in 2001 was used to define the types of policy influence when analyzing the interview data⁵:

Expanding policy capacities:	<input type="checkbox"/> Improving the knowledge or data of certain actors; <input type="checkbox"/> Supporting recipients to develop innovative ideas; <input type="checkbox"/> Improving capabilities to communicate ideas; <input type="checkbox"/> Developing new talent for research and analysis.
Broadening Policy Horizons:	<input type="checkbox"/> Providing policymakers with opportunities for networking or learning within their jurisdiction or with colleagues elsewhere; <input type="checkbox"/> Introducing new concepts to frame debate, putting ideas on the agenda, or stimulating public debate; <input type="checkbox"/> Educating researchers and others who take up new positions with a broader understanding of issues; <input type="checkbox"/> Stimulating quiet dialogue among decision-makers (and among, or with, researchers).
Affecting Policy Regimes:	<input type="checkbox"/> Modifying existing programs or policies; <input type="checkbox"/> Leading to the fundamental re-design of programs and policies.

Expanding policy capacities takes place in a wide variety of IDRC-supported programs and projects. It focuses particularly on improving researchers capacities to conduct policy relevant research and test its application. This includes supporting new research, the development of new fields of research, enhancing researcher capacities to work on problems or issues as distinct from carrying out disciplinary research, as well as enhancing their capacities to communicate knowledge and ideas to a diverse audience.

Broadening policy horizons focuses on the perspective of both researchers and policy/decision makers. Generally, it has to do with increasing both the availability of knowledge, as well as the comprehensiveness of this knowledge. For example, the accessibility and completeness of knowledge increases through project and networking activities that bring together researchers, policy makers and others in the policy community:

- ☐ Increasing the stock of policy relevant knowledge;
- ☐ Introducing new ways of thinking into the policy arena;
- ☐ Making sure knowledge is available to policy makers in forms that make it possible for them to use it.

Essentially, broadening policy horizons is about the means and relationships that translate research into knowledge which policy makers can use to change policy.

Affecting policy regimes is about the actual use of research in the development of new laws, regulations, or structures. This category of influence is typically considered “real” influence and is often considered a key indicator of influence. This is the least common type of influence following from research although it is not unheard of.

This framework allowed us to report on the various activities and outcomes associated with the project and which are considered as being, either directly or indirectly, a “type” of policy influence. Further, our experience with this framework demonstrated its utility by capturing the type of work IDRC does

⁴ Lindquist, Evert (2001). “Discerning Policy Influence: Framework for a Strategic Evaluation of IDRC-Supported Research”. Available at: http://network.idrc.ca/file_download.php/discerning_policy.pdf?URL_ID=12177&filename=10359907080discerning_policy.pdf&filetype=application%2Fpdf&filesize=205144&name=discerning_policy.pdf&location=user-S/

⁵ This framework has since been modified to better reflect IDRC’s organizational culture and language.

in supporting development. It enabled us, in analysis, to make both direct and indirect linkages to policy influence. In other words, this framework allowed us to articulate TEHIP's contribution to policy and to capture and report on those contributions.

Chapter II

Context⁶

Tanzania is the largest of the east African countries with a population estimated to be 34.5 million (2002), 70% of which live in rural areas. It is one of the poorest countries in the world. Its economy is heavily dependent on agriculture, which accounts for half of GDP, provides 85% of exports and employs 80% of its work force. More than 50% of Tanzanians live below the poverty line.

Tanzania gained independence in 1964, at which time Tanganyika and Zanzibar merged to form the Republic of Tanzania. Since 1995, the country has enjoyed a multi-party democracy under President Benjamin William Mkapa who came to power during the country's first democratic elections in November 1995.

I. Health Sector Reforms:

In the 1970s, development assistance was directed towards the rural areas. Communities responded by building dispensaries. As a result, there was an over-extension in the rural areas that the central government could not support. Buildings began to fall apart and drug shortages ensued – there was an overall deterioration of the health system. Tanzanians began seeking ways to revive the system.

In 1993, the central government passed the Health Sector Reform Act in an effort to better utilize health resources, improve primary care, increase user access, and cut rising costs. These reforms represent significant philosophical, organisational, managerial, and financial changes to health care planning and services. More important perhaps, is the fact that the government is decentralizing the health care system, including the devolution of management and budgetary control to the district level. As explained by a senior level Ministry of Health official:

...initially, the MOH was the sole provider of health services [and] everything came from the centre. Then we decentralized all of the functions. For example, we decentralized the resources – human and financial. Now we provide the guidelines, monitoring and evaluation, and training. We also provide capacity building to the periphery so that they can take up the core functions. Decentralization means devolution – giving the districts power and accountability – while assisting them to develop district health plans (#1, interview, Tuesday 24 September, 2002).

The central government anticipates that the decentralization process will empower the districts to improve health at the local levels by improving access, quality and efficiency of primary health care services.

The Health Sector Reform program set the following objectives:

- I. Improve access, quality and efficiency of primary health (district level) services;
- II. Strengthen and reorient secondary and tertiary service delivery in support of primary health care;
- III. Improve capacity for policy development and analysis, development of guidelines for national implementation, performance monitoring and evaluation, and legislation and regulation of service delivery and health professionals;
- IV. Implement a human resource development program to ensure an adequate supply of qualified health staff for management of primary, secondary and tertiary services;

⁶ Sources of information presented in this section include: the Project Document (June 1996) and the TEHIP website http://network.idrc.ca/ev.php?URL_ID=3170&URL_DO=DO_TOPIC&URL_SECTION=201

- V. Strengthen the national support systems for personnel management, drugs and supplies, medical equipment and physical infrastructure management, transport management and communication;
- VI. Increase the financial sources and improve financial management;
- VII. Promote private sector involvement in the delivery of health services;
- VIII. Within the sector-wide approach (SWAp) develop and implement a system of donor involvement, coordination, monitoring and evaluation.

II. World Development Report 1993:

Health systems in low-income countries face enormous problems including the high incidence of communicable diseases (e.g., malaria, HIV/AIDS and TB) and chronic illnesses (e.g., diabetes, hypertension). These problems increase the costs associated with health services. When public health budgets and international assistance are under pressure of macroeconomic reforms and donor fatigue the problems are exacerbated. Structural reforms to health care programs have led to significant cuts in public spending, with an accompanying decline in services. Together, these factors contribute to the lessening of equitable access to health services, a decline in the health status of populations and the demoralization of health workers.

In 1993, the **World Development Report (WDR) “Investing in Health”** addressed these problems with a series of proposals. One such proposal was that, given the scarcity of available resources for health, especially in low-income countries, the planning for and setting of priorities for essential health interventions should be based on burden of disease and cost-effectiveness analysis. The analysis of health systems showed that many developing countries misallocate these scarce health resources toward low cost-effective interventions, coupled with inefficiencies in planning and highly centralized decision-making. The report asserts that the provision of packages of essential clinical and public health interventions to 80% of the population in low-income countries would bring about a 32% reduction in the burden of disease. The World Bank estimated that these packages would cost, in low-income countries, roughly US\$12 per capita, per year to deliver; at the same time, they acknowledged that this per capita allowance was greater than most health budgets allow in the majority of low-income countries.

III. The Opportunity – TEHIP:

In October of 1993, IDRC convened an international conference to meet with representatives of the World Health Organization (WHO), the World Bank and other donor organisations, and representatives from developing countries to consider the findings and recommendations presented in the report. The WDR hypothesis that packages of essential clinical and primary health interventions can and should be delivered effectively using analyses based on burden of disease and resource allocation was debated and discussed. Conference participants concluded that this should and could be tested. Based on this recommendation, IDRC, with the support of CIDA, subsequently developed what became the Essential Health Interventions Project (EHIP).

Conference participants also decided that in order to properly address the issues of burden of disease and cost-effectiveness, EHIP should also focus on a third topic: improving the planning and management of health services at the district level.

The founders of EHIP agreed that the project should be developed and implemented as a demonstration project in a country in East, Central or Southern Africa. After receiving several proposals, Tanzania was deemed a good fit and was selected as the host country for two reasons. First, the World Development Report advocated devolution of responsibility to local authorities, and the Tanzanian government was advocating decentralisation in its health sector reforms. This fit can be seen in the sentiment expressed by Mr. Mrope, the Permanent Secretary for the Ministry of Health during this time:

He [Mrope] concluded that – Tanzania is committed towards greater decentralisation on health and other sectors in order to empower districts to take increased responsibility for solving their own problems...TEHIP is not only timely, but also a necessary catalyst to the decentralisation process currently taking place...⁷.

The second reason for selecting Tanzania as the host country is that it is one of the poorest countries in the world and could potentially benefit greatly from a project of this scope. “TEHIP activities... and other activities in selected districts will provide information for the implementation of reforms in other districts”⁸.

In agreement with the Tanzanian Ministry of Health, two districts were selected to participate in TEHIP: Rufiji and Morogoro Rural. EHIP thus evolved into TEHIP and efforts to initiate the implementation of the testing started soon after.

TEHIP IS ACTIVE IN TWO RURAL DISTRICTS OF TANZANIA, EAST AFRICA



Combined Population approximately 800,000 people
Source: TEHIP website (2003)

⁷ Minutes of the EHIP IAC Meeting – 18 May 1996 (Geneva): Final Version dated 4 July 1996:p. 3

⁸ Minutes of the EHIP IAC Meeting – 18 May 1996 (Geneva): Final Version dated 4 July 1996:p.3

Chapter III

The Project

I. Project Goal and Objectives⁹:

TEHIP was developed as a four-year research and development project starting in 1996:

Box 1: Project Goal and Objectives

Goal: To test the feasibility and measure the impact of an evidence-based approach to health planning at the district level.

Objectives:

- ❑ Strengthen district level capacity in Rufiji and Morogoro-Rural Districts to plan and set priorities using burden of disease and cost-effectiveness analysis for resource allocation;
- ❑ Increase district level capacity to effectively deliver the selected health interventions;
- ❑ Assess and document lessons learned in district health planning and management information systems and processes; and
- ❑ Measure the overall impact of delivered health interventions in terms of burden of disease reduction.

In order to test the feasibility of the use of evidence in health planning, a research component was developed. Specifically, the project sought to answer three key questions:

1. How and to what extent can Tanzanian district health plans be more evidence-based?
2. How and to what extent can evidence-based plans be implemented by decentralized district systems?
3. How, to what extent, and at what cost can such evidence-based plans have an impact on population health?

All of TEHIP's research activities were designed to answer these three core questions; its research program was organized into three components or themes focusing on: (a) health systems; (b) health behaviours; and (c) health impacts.

(a) Health Systems:

The health systems research component focused on district health planning, prioritization, and resource allocation processes. The principal research objective was:

- ❑ To determine how, and to what extent, district council health management teams can use locally generated information on burden of disease, cost-effectiveness, health system capacity, and community preferences to plan, set priorities, and allocate health resources.

This research component was concerned with process, content, context, and implementation issues, as well as the linkages among them.

⁹ Information on the project goal and objectives was obtained through project documents and the TEHIP website: http://network.idrc.ca/ev.php?URL_ID=3170&URL_DO=DO_TOPIC&URL_SECTION=201&reload=1062764806.

(b) Health Behaviours:

This component focused on household health-seeking behaviours in relation to essential health interventions. The principal research objective was:

- ❑ To identify and analyze trends at the household level in the use of selected essential health interventions provided through district health management team plans with respect to spatial, social, and economic determinants.

The household level is where health seeking behaviours, health service utilization, risk perception, household decision-making, and household expenditures for health are most likely to change. As such, it was expected that household behaviours may influence the very nature of CHMT planning processes and in turn be affected by CHMT plans. This component also planned to explore ways to bring "community voice" into a district's health planning process.

(c) Health Impacts:

This research component focused on the demographic and health effects of health system process changes at the district level. The principal research objective was:

- ❑ To document burden of disease for priority setting and to quantify changes in the burden of disease to assess the impact of health reforms.

To measure short-term changes in the burden of disease, such as child mortality rates, TEHIP used a demographic surveillance system (DSS) to continuously monitor births, deaths, and migrations in the Rufiji and Morogoro Rural districts. Without regular censuses or registration of births and deaths, household surveys have evolved as an efficient and cost-effective way to obtain household data in Africa's rural areas.

Together, these three components culminated in practical tools for evidence-based planning processes at the district level as an outcome of the research and development.

II. The Policy Intent:

From the beginning, it was recognized that to bring about changes at the district level the project would need to influence health policies at the national level. Minutes from EHIP Steering Committee meetings revealed discussions that reflected this:

it was suggested that [the findings (information and implementation experience)] should be strengthened to reflect the notion that information and experiences gained from [T]EHIP be considered by the Ministry of Health in the development or modification of health policies¹⁰.

Getting information and experiences "considered" by the Ministry was recognised as a challenge that needed to be addressed. To meet this challenge, a suggestion was made to involve members of the policy community including high-level officials of the Ministry of Health:

¹⁰ Minutes (Final Version) – EHIP Steering Committee, Dar es Salaam, 5-6 October (Minutes dated December 1995):p4.

Mr. Shirima [Minister of Lands, Urban Development and Housing, and former Permanent Secretary for Health] noted that while this was a good idea, one of the challenges would be to get EHIP data and information into a format that would be meaningful and helpful to policymakers. Mr. Shirima suggested that one way to assist with this issue was for Tanzania to have key persons (such as Principal Secretaries) involved with and fully familiar with EHIP, especially with respect to the linkages between EHIP and the Health Sector Reform process¹¹.

Steering Committee members, project staff and others in the health sector policy community who were involved with the project design understood the need to form linkages between the research and the users from the beginning in order to bring the research results into the reform process. The Steering Committee responded to these needs by informing the anticipated users through meetings and other fora:

Mr. Mrope [Permanent Secretary at the time] informed us that a meeting has been scheduled for Wednesday with representatives of the Prime Minister's Office, the Planning Commission and the Treasury so that their input could be incorporated into the [project] document¹².

These documents also suggest interest on the part of the Ministry of Health to expand results and experiences to a broader scale: *"Dr. Upunda indicated that TEHIP is providing an opportunity to test health sector reform directions in two districts. Activities will be documented in order to provide information for other districts as they apply the lessons learned by Rufiji and Morogoro (Rural)"¹³.*

Bringing research information to policy and decision makers is only effective if what reaches them demonstrates that evidence-based planning and management is useful in implementing and delivering health services and interventions. Thus decisions needed to be made about what kind of data and information could be useful and of interest to policy makers. Documentation from the project files reveals the thinking behind the project in terms of how to influence policymakers, what mechanisms to use, and how to make the data meaningful to the users:

The issue of what research data should be provided to the TEHIP districts was raised. It was felt that the issue is to determine what data is useful and of interest to DHMTs, and the cost of that should be calculated as part of the intervention. It may require time for DHMTs to see how research (e.g., data) can assist in the development of effective plans – a pragmatic approach is necessary. The project is concerned with increasing the ability of managers to use data and make decisions on the basis of data – not with increasing the capacity of the manager to do research¹⁴.

The intent, as stated here, is to enhance the capacity of local health managers to use information generated from the research as evidence in order to make informed decisions, rather than enhance their capacity to conduct the research.

III. The Project Outputs – The TEHIP Toolbox:

To help meet its objectives, TEHIP has developed or refined a variety of powerful planning tools and strategies that allow district CHMTs in the two districts to collect and analyze information more effectively. These tools provide the evidence that enables the CHMTs to set priorities and allocate health resources as part of their planning processes. The range of tools includes: (1) District Burden of Disease Profile, (2) District Health Accounts, (3) District Cost Information, (4) District Health Service Mapping, (5) Community Voice, (6) District Simulated Basket Funding, (7) Strengthening District

¹¹ Minutes (Final Version) – EHIP Steering Committee, Dar es Salaam, 5-6 October (Minutes dated December 1995):p4.

¹² Trip Report – J. Finlay 1996. Dar es Salaam and Boston, April 15-19 1996: p.2

¹³ Same as above: p.11

¹⁴ Minutes of the EHIP IAC Meeting – 18 May 1996 (Geneva): Final Version dated 4 July 1996: p. 9.

Health Management and Administration, (8) District Integrated Management Cascade, (9) Community Ownership of Health Facilities, and (10) Project Operations Committee Meetings.

Since the majority of respondents shared their knowledge of TEHIP in relation to the Burden of Disease Profile, the District Health Accounts, Simulated Basket Funding, the Cascade System and the Community Ownership of Health Facilities, this report focuses on these particular tools and strategies.

District Burden of Disease Profile

The Burden of Disease (BoD) tool aimed to simplify, package and communicate complex information on vital statistics and the local burden of disease in a graphical format for planning purposes. The tool was developed for use by the CHMTs and others involved in health planning at the local level. In order to develop a BoD profile, the project had to incorporate the use of district demographic surveillance systems to provide the burden of disease information required for the annual planning cycles. Demographic surveillance also provided a monitoring system that allowed project staff to monitor the impact of the TEHIP interventions. This included Mortality Surveillance Systems in each district that followed large samples of populations (typically in excess of 80,000) through periodic monitoring at the household level of all migrations, births, deaths, and causes of death. It was expected that if the Burden of Disease approach to evidence based planning worked well, recommendations could be made to extend the network of districts hosting demographic surveillance systems into a National Sentinel Surveillance (NSS) System. Since 1992, Morogoro Rural had a functioning mortality surveillance system funded by DfID and implemented by the Adult Morbidity and Mortality Project (AMMP). AMMP agreed to provide data from the Morogoro Rural Mortality Surveillance System to TEHIP in return for TEHIP providing financial support to the District for health interventions. As well, both TEHIP and AMMP expressed intentions to co-finance and co-manage the introduction of a full DSS in Rufiji District.

District Health Accounts

The District Health Expenditure Mapping tool was developed to provide CHMT planners with a one-page summary of expenditures and a one-page graphical picture of their annual Comprehensive Council Health Plans (CCHPs). The tool was intended to help districts understand the accumulated total financial resources that they had budgeted and spent; the sources from which they draw their revenue; and the major interventions and activities to which these funds were allocated. The tool integrates information from the District Burden of Disease Profile and the District Cost Information System. According to TEHIP documents, this tool aimed to:

- ❑ Provide basic analyses of budgets and expenditures to check against priorities, norms, and standards;
- ❑ Reduce the complexity of CCHP budgets for health planners;
- ❑ Provide a graphical display of complex numeric information;
- ❑ Provide summary information on resource source and allocation for both budgets and expenditures;
- ❑ Guide CCHPs to be more comprehensive in capturing all potential sources of revenue;
- ❑ Assess CCHP implementation (budget versus expenditure); and
- ❑ Facilitate accountability and transparency.

District Integrated Management Cascade

The need for the District Integrated Management Cascade arose from the fact that it was logistically impossible for CHMTs to effectively implement integrated supervision. It was also observed that despite the implementation of the health sector reforms and the creation of the CHMTs, communication and engagement of front line health workers in the reforms had been minimal. The District Integrated Management Cascade strategy was designed to promote the participation of front line workers in district health plan activities and health sector reform implementation. The goal is to

improve the quality of health services in districts by creating a “functional hierarchy” below the CHMT: this structure would facilitate the distribution of equipment and drugs, while providing supportive and continuous supervision, training, referral, and monitoring of health activities. Is so doing, this strategy would also encourage optimal communications and feedback between staff of health facilities and CHMTs.

Community Ownership of Health Facilities

This strategy aims to:

- ❑ Develop and establish a more affordable and sustainable mechanism for the rehabilitation and maintenance of health facilities;
- ❑ Promote ownership of health facilities by local communities;
- ❑ Build community self-confidence in the rehabilitation and maintenance of local health facilities; and
- ❑ Impart appropriate skills to district and local leaders on community labour-based approaches to rehabilitation and maintenance.

Capacity building at the District level was an important component of TEHIP and was facilitated through the participation of local community leaders and members in the planning, management and effective delivery of health services and resources in the communities. The rehabilitation of health facilities was a development intervention that was selected in order to help foster ownership and self-confidence in community members, while developing skills of the district authorities and local leaders on community labour-based approaches to rehabilitation and maintenance. From the outset, TEHIP set aside a modest amount of funds to compliment funding from the District authorities and communities to uplift the conditions of dilapidated dispensaries. The participation of communities consisted of setting out complete workplans, contributing labour and materials, and carrying out the rehabilitation and maintenance.

District Simulated Basket Funding

In 1996 it was recognized that for almost all of the District health budgets there was relatively little cash funding to plan new activities. In order to test innovations in the planning process TEHIP needed to inject additional funds into the District health budgets. The World Development Report estimated that low-income countries such as Tanzania would need to spend about US\$12 per capita in order to deliver a minimum package of essential health interventions to 80% of those in need. Given the annualized value of infrastructure and trained staff plus a recurrent expenditure of US\$4.50 USD, it was estimated that Tanzania had a standing investment of about US\$8 per capita per year. TEHIP felt that an increase of US\$2 would not be out of reach for policy makers if it could be demonstrated that such an investment would actually result in a 20-30% reduction in the burden of disease as predicted by the World Bank. Therefore TEHIP made available a contribution of up to US\$2 per capita per year to Morogoro Rural and Rufiji Districts starting in 1997 (about 700,000 people). There were relatively few conditions. The primary condition was that the CHMTs would need to show that the funding was being invested consistent with the evidence from the local burden of disease, and that it was being spent towards supporting, directly or indirectly, interventions that were known to be cost effective. There was also a ceiling placed on the use of funds for rehabilitation of health facilities, District Medical Officer's office support and transportation. In this way, it was anticipated that the approach could indicate and point to certain basic features of the SWAp Health Basket funding to District Councils and provide useful experiences to the MOH.

Chapter IV

The TEHIP Influence

As acknowledged in the literature, tracing policy influence, especially from a single project or intervention is particularly difficult. Influences on policies are both numerous and varied and are facilitated by factors both internal and external to the project itself. Nonetheless, the respondents within this case were unanimous in recognizing significant and positive influences of TEHIP on national health policies. TEHIP's work with the district health services in both Morogoro-Rural and Rufiji was seen as having influenced the thinking and actions affecting how research data and other kinds of evidence can be used to make decisions about health policies, programs and priorities. This influence occurred both in terms of (1) **the processes** of policy formulation, implementation and reform; and (2) **the content** of the policies, programs and reforms. Following this, an analysis of these influences is considered within the overarching framework developed by Lindquist (2001).

I. Processes:

Several informants reported that the Ministry of Health was frequently making choices subject to pressures from development and other agencies regarding the allocation of resources and the subsequent selection of interventions. Demographic surveillance data, analyzed and made accessible using TEHIP-developed tools, was widely credited with making available reliable, relevant and understandable information to assist with these choices. The Burden of Disease (BoD) and district health accounts tools were repeatedly cited as examples. Describing TEHIP's influence on how policies and reforms were formulated and implemented, respondents mentioned the following:

- ❑ Burden of Disease and resource allocation tools
- ❑ Simulated Basket funding
- ❑ Community participation and ownership of health facilities
- ❑ Cascade system

Burden of Disease and Resource Allocation Tools

Several TEHIP-developed tools are widely recognized throughout the health sector by the Ministry of Health, policy implementers at both the local and national levels, and by other donors working in the health sector. The BoD and resource allocation tools were by far the most frequently cited examples of TEHIP's influence on health policies and the health sector reforms (HSRs). The evidence produced by these tools is providing the central government with the evidence they need to formulate sufficient health policies and the means to monitor the allocation of health funds to make them more effective. More specifically, both the BoD and resource allocation tools have assisted the MOH with implementing the HSRs:

Now we have a tool to give to all the districts: burden of disease and allocation of funding...the burden of disease and the funding allocation tools are one of the main contributions of TEHIP to the HSRs (#1, interview, Tuesday 24 September, 2002).

Through the use of these tools, TEHIP has demonstrated how the districts can use "evidence" in relation to matching resource allocation and interventions to the burden of disease as found in the district:

Burden of disease, planning with statistics – before the Ministry talked about the information but they didn't see how they could use it, didn't see how they could display it. But now they do – and not just the evidence, but how to use the tools to give priority and so that districts can make decisions intelligently (#4b, interview, Wednesday 25 September, 2002).

The HSR process involves the decentralization of the planning process from the central government to the districts such that now it is the districts that are responsible for developing health plans and prioritizing health service delivery and health interventions. Nevertheless, the central government is still responsible for reviewing and approving district health plans. The BoD and resource allocation tools have contributed positively to this review process by providing MOH staff with tools to assess district health plans. According to a senior Ministry of Health official, the BoD and resource allocation tools developed by TEHIP have enabled Ministry staff to assess the proposed district plans. He went on to state that because of these tools he and his colleagues have seen considerable improvement in the health plans from the districts, particularly when compared to previous district health plans (#1, interview, Friday 27 September, 2002).

A number of key informants credited the TEHIP tools for improving the district planning process in both Morogoro-Rural and Rufiji Districts. Indeed, several of them noted that the district health plans submitted by Morogoro-Rural and Rufiji were the best in the country and that health review teams have reported big differences between the TEHIP-supported districts and other districts.

The ideas and concepts of planning and prioritizing are also spilling-over into other districts. The Regional Coordinator (Anglophone Africa) of the International Trachoma Institute stated that they were also reviewing the health plans in 20 districts for the implementation of trachoma control. According to him, when they collected and reviewed the plans they saw a prioritization list “*which is not normally the case*”. He directly attributed the systematic planning based on disease frequency showing up in the district plans to “*TEHIP and the way they have interacted with the Ministry of Health trainers*”.

At the district level, these tools have enabled council members (e.g., District Executive Directors, District Medical Officers), and health managers (e.g., CHMTs) to produce the evidence they need to develop these plans and priority lists. According to one District Medical Officer, TEHIP provided a “spark” to use morbidity and mortality information collected from the districts:

I call it the TEHIP “spark”. The spark was to actually use the information collected. AMMP was here long before TEHIP and collected a lot of information but we never used the information. It wasn't until TEHIP came here that we used the information (#4b, interview, Friday 4 October, 2002).

Although AMMP was in the district collecting similar information before, several informants felt that it was TEHIP that showed district level officials and managers how to use the information for planning and prioritizing purposes. The ability to plan and prioritize health services and interventions was also seen as having raised the level of confidence of district planners and health managers in producing acceptable health plans. Several respondents reported that they see the district planners as being more confident in both planning and assessing their plans. In part, this may be due to the fact that the district now has more control over its own planning, prioritization, and resource allocation for health services and interventions:

The central government used to send us funds and plans for how to allocate those funds. Now they just give us an estimated amount of funds. We can then budget our priorities with these funds, along with the activities to achieve these priorities and interventions (#4b, interview, Monday 30 September, 2002).

The BoD and resource allocation tools have demonstrated to policy and decision-makers, as well as policy implementers, at both the local and national levels that effective and efficient district health

plans can be produced using data and information collected at the district level. Given this, it is no surprise that the Ministry of Health expressed its desire to expand the use of these tools to other districts:

BoD tool is very useful to us. Along with the budget-mapping tool, it enables us to see clearly what is happening in the district. Now the Ministry of Health wants other districts to use the budget mapping tool and the BoD tool (#4a, interview, Friday 4 October, 2002).

According to the head of health programming of a major donor, the demonstration between the BoD data and the mismatch with the allocation of funding was an important issue that needed to be addressed. While carrying out this evaluation, we observed that several other donors and key informants were aware of the Ministry of Health's interest in the BoD tool but didn't yet know of its widespread use(s).

Simulated Basket Funding

A key element found within the TEHIP process was the "simulated basket funding" or top-up provided by the project. Initially, the project provided an additional US\$2 per capita to each of the two participating districts towards their health budgets. The additional funds were used for drug supplies, transportation, computers and computer software, training and capacity building, and the rehabilitation of health facilities. Used in conjunction with the BoD and resource allocation tools, this "top-up" enabled district health planners to implement the selected health services and interventions and to deliver them effectively and efficiently.

Early on in the planning process, however, it was discovered that the districts actually had difficulties using the additional funds. This "difficulty" soon became known as the concept of "absorptive capacity". Essentially, the districts could plan for but could not accurately spend the additional funds available to them. As one respondent explained, *"the CHMTs were very surprised that they couldn't absorb or spend the extra funding. They were very surprised that they didn't meet their own plan"*.

The realization that the district's absorptive capacity was weak prompted a decrease in the amount of funding the project provided to US\$1 per capita per year. This decrease was seen as a step towards sustainability – once the district could demonstrate they could actually spend and use the additional funds, small increases of funding were transferred.

The concept of topping up, or providing additional funds to the district health "basket" is now being implemented at the national level, with its own department within the Ministry of Health. International donors working in the health sector provide the additional funds, which are collected and put into a "basket fund". This basket was agreed to at a level of US\$ 0.50 per capita. A respondent from the Ministry of Health directly attributed the Ministry's change in its health funding process to the TEHIP "top-up" model.

This new national basket system, however, is not without its own limitations and constraints. First, the "basket" does not allow for donors to distinguish their specific contributions to the health sector. Currently, performance management and accountability requirements dominate donor-driven evaluations. Accountability requirements rely on evidence that demonstrate value for money, as well as showing very specifically the contribution made to the development process. A joint funding process where specific donor funds are not visible does not lend itself to evaluation aimed at performance management and accountability. This concern is supported by a national level government official who commented that donors would have to be satisfied with good evaluations showing achievements of the "basket" as whole, and with not being able to claim credit for results specifically attributable to them.

Second, and perhaps more significant, is that many respondents – particularly at the local level – felt that there were too many constraints tied to the new national basket system. They stated that the system often determined how to spend the money, what to spend it on and how much could be spent on certain items or expenditures (e.g., transport, training, capital resources such as computers). For example, one local policy implementer claimed that not more than 20% of the basket funds could be spent on transportation, even if it were necessary. Another respondent further explained the constraints placed on the districts: “*restrictions on equipment mean that dollars go to workshops and not service delivery*”. The TEHIP basket funds were not subject to such conditions.

The interviews suggest that there are still inconsistencies within the health management systems with respect to resource allocation and funding processes. This means that although a district may need to reallocate more resources towards anti-malarial interventions in order to lower mortality and morbidity levels, such a move may be constrained when it comes to implementation of the selected interventions due to restrictions and conditions imposed by resource allocation processes within the basket system.

Community Participation and Ownership of Health Facilities

Community participation was central to the TEHIP approach. The TEHIP team observed that “community participation” approaches in research and development projects over the past two decades had left many in the South rather sceptical of its value. To reconcile this, TEHIP worked with national and local level health managers and workers to make this approach, and the outputs, more meaningful to local people. Accordingly, the TEHIP approach incorporated different yet complimentary activities that would further community empowerment. These activities included: (1) incorporating community preferences in planning and prioritization processes; and (2) community mobilization towards the rehabilitation of health facilities. Linked together by participatory action research methods and tools, these elements demonstrated to the villagers both the value of their input and the benefits of the health service and delivery changes.

To bring the “voice” of the local people into the district health plans, CHMTs worked with several villages to find out what the most pressing issues were and how villagers expected them to be resolved. Using participatory research tools, these issues were then prioritized according to villagers’ needs.

Several respondents reported that the voices of the communities in the planning processes had translated into changes in the health service and delivery systems. They felt that these changes provided the incentive and motivation for community members to become more involved in the process by taking ownership and responsibility of certain aspects of it. As one national level government official claimed, “*people’s attitudes have changed for the better in the TEHIP areas*”. Additionally, some respondents perceived that this “bottom-up” approach had also attracted and influenced other government departments to use a similar approach:

Contrary to what was done before, now our planning is from the bottom-up. We have a solid plan and other departments are copying aspects of our approach...such as bring [sic] in community participation through the “village voice” tool (#4b, interview, Friday 4 October, 2002).

Many of the health facilities in the rural areas, particularly the dispensaries, were neglected over the years due to (1) a lack of funding from the central government and (2) a lack of responsibility at both the national level and the district level. Community members felt that since the central government was responsible for the delivery of health services, they were also responsible for the up-keep of the facilities.

In order to counter this attitude and to deliver the needed essential services to communities more effectively, the TEHIP team invited Tanzanians from other organizations well grounded in community mobilization activities to assist villagers in the rehabilitation of numerous dispensaries. Since the villagers had already realized some of the benefits from their participation, they were willing to take on the challenge of restoring the health facilities. This process further encouraged the districts, including the local people, to take *ownership* and *responsibility* of the entire system rather than simply be responsible for the maintenance and operation of the facilities:

The TEHIP approach – the approach taken to rehabilitation and maintenance of health facilities and infrastructure – is the idea that the community cannot only take on the burden of maintenance and operations but can take responsibility and ownership. This was a novel idea (#3, interview, Thursday 3 October, 2002).

Thus according to local policy implementers, other researchers, and donors looking at community involvement, TEHIP has demonstrated the value of, and some processes for, devolving ownership and responsibility to the communities being served.

TEHIP's approach to community participation also acknowledged the interaction between community members and paid health researchers. TEHIP employed local people to collect data that is used to monitor the provision of services, access to and utilization of health facilities, and the morbidity and mortality levels within the two TEHIP-supported districts. Monitoring data were collected primarily through surveys, but also through village meetings and other local gatherings. In addition, retired local doctors who are not only members of the local community, but who were also knowledgeable of local illnesses, conducted verbal autopsies (#2, interview, Sunday 29 September, 2002). These two elements together sought the inclusion of local knowledge and evidence generated by local people.

Community participation was an integral component within TEHIP. The strategic decisions the team made, in collaboration with the MOH and the district, to provide services first in order to demonstrate the value and benefits of the project were apparently successful in giving the local people the incentives and motivation to take ownership and responsibility for health service provision and delivery. The rehabilitation process also provided communities with the opportunities to gain skills in various capacities: planning, architecture, engineering etc. Taken together, the three elements discussed above have contributed to the changes reported by interviewees concerning the capacity and confidence of the local communities in their efforts to make the health system more effective and efficient.

Cascade System

The cascade system is an integrated management and communication system that evolved after the project had started. As explained by a TEHIP researcher, a review at the end of the first year of the project found that:

...supervision [in the districts] was very weak, so they came up with the cascade system which TEHIP supported. This [system] is a result of that initial finding. For example, there was uncertainty about when funding would be received from the funding sources. When we went through the budget we found that the CHMTs didn't receive the promised funds (#2, interview, Wednesday 2 October, 2002).

This same system, and its evolution, was described in a slightly different light by a TEHIP staff member:

...supervision [in the districts] was very weak and realisation of this stimulated the creation of a cascade system through which delegation, involvement and responsibility for health delivery could be shared with the lower but important cadres that make up the district health service delivery system. Activation of the cascade system was also facilitated through TEHIP funding into the district health plan as a stakeholder...these funds could then be used to activate the cascade system through purchase of radios, solar power systems, motorbikes, bicycles, etc. (#4b, Personal Communication, November 30, 2003).

The cascade system provides a line of responsibility and delegation from the villages up through to the central level (MOH). The implementation of this “cascading” system of authority and responsibility allows for increased communication among the front line workers, the CHMTs and the MOH staff. One outcome of the implementation of this system as reported by donors and local officials, is the improved effectiveness of the distribution of drugs in the villages, particularly at the dispensaries. As explained by one respondent, the “*Cascading supervision has improved the dispensaries. The drugs can now reach dispensaries [and as a result] people feel this system has improved dispensaries*” (#3, interview, Wednesday 25 September, 2002).

Another reported outcome of the cascade system involved the improvement of communication between different groups of health care workers and management at the district level. This resulted in faster responses and mobilization of treatments and information. For example, a district level medical officer and his health management team described situations where they were able to provide treatment to people by radio through “*communication between the DMO and dispensaries, [and that] it only took 12 hours to mobilize drugs and information*”. Previously, communication would have taken several days due to poor roads and periodic flooding from the river throughout the Rufiji District. Faster response times are especially important during floods that are often accompanied by malaria and cholera outbreaks.

TEHIP Processes and Policy Influence

Taken collectively, the above processes influence how policies, programs and reforms are developed and implemented. Reported changes include funding and investment at the district level, addressing drug shortages and supply chains, rehabilitation of the health facilities and capacity building of the CHMTs especially in implementing services and interventions. But based on a range of direct and indirect comments by all categories of respondents, the most significant contribution appears to be the instilling of the “culture of planning”. As one respondent states, “*...building the culture of planning – before TEHIP we didn't know the abc's of planning; how to plan, prioritize, allocate resources – this is the biggest contribution to the districts*”. An extension of this culture, is the widespread view that TEHIP's experience in these two districts has demonstrated at both the central and district levels how health improvements can initially be achieved with less than the WDR 93 projected US\$12 per capita when resources are allocated based on evidence.

II. Content:

Respondents gave numerous examples of how TEHIP-generated or TEHIP-disseminated information contributed to very real changes regarding the selection and implementation of health interventions with respect to district and national policies and programming, as well as providing concrete input into the central government's strategic health plans. When discussing changes to health policies and programs, respondents most frequently mentioned the following:

- ❑ Guidelines for District health plans and the NSS
- ❑ National focus on malaria programs, antimalarial drug policy and ITNs
- ❑ IMCI

Guidelines for District Health Plans and the NSS

The previous section describes how the TEHIP tools contributed to the changes regarding how district health plans are prepared, and how evidence provided by the tools are used for prioritizing and resource allocation. These contributions led to subsequent changes in the content of the district health plans as well as to concrete changes at the national level in terms of implementing a national surveillance system (NSS) for collecting the evidence needed for prioritization and resource allocation.

Respondents frequently noted that TEHIP “contributed to the development of guidelines for district health planning based on the [their] experience. Now it’s a national item” (#3, interview, Monday 7 October, 2002). For some, it was the tools that especially contributed to the development of the guidelines:

They are no longer ‘TEHIP’ tools – they are national tools. As long as we support the government we support the tools. They are in the guidelines and we [as a donor] contribute to that process. The national guidelines are an adaptation of the TEHIP tools (#3, interview, Monday 7 October, 2002).

The translation of health policies and guidelines into Programs of Work is underway and TEHIP experiences and lessons are being used as input into the Program of Work and Action Plan (2002/03). Specifically, the MOH and its partners agreed to hold a situation analysis to review district health services and they list TEHIP as an input into this process. The Program of Work also documents TEHIP as providing input into both the “Essential Health Packages Strategy” and the “Management of Health Training Institutions”. Both of these strategies are under the responsibility of the central Ministry of Health¹⁵.

National Focus on Malaria Programs, Anti-malarial Drug Policy and ITNs

Perhaps the most notable result of the BoD tool and the use of evidence from the districts was in fostering the realization that malaria was a significant health problem in Tanzania – more so than any other disease, including HIV/AIDS. Yet, evidence produced from the BoD and resource allocation tools showed that resources towards malaria interventions were less than what was needed. As one respondent noted, “*malaria is such a big problem and the districts didn’t know how to deal with it. But now they allocate funding and interventions based on the BoD*” (#4a, interview, 2 October, 2002).

The tool further demonstrated the need for more resources from the central government towards malaria interventions. Previously, the MOH placed more emphasis on other diseases and interventions and gave scant attention to the malaria issue. However, the “*BoD tools are very clear and worked to help justify district funding towards malaria. The districts knew this was the number*

¹⁵ *Inputs to Develop a Programme of Work 1999/2000 - 2001/2002 and Action Plan 1999/2000. Draft 1, September 2002: pp.4-11.*

one problem but the central government didn't budget interventions like that" (#4a, interview, 2 October, 2002).

This new attention to malaria was also attributed, at least in part, to TEHIP's "malaria mapping" tool, Mapping Malaria Risk in Africa (MARA), especially when combined with the BoD tool. The MARA mapping tool shows where, and at what point throughout the year, people in Tanzania are most susceptible to malaria. This has assisted other donors who work in the area of malaria interventions. For example, PSI (Population Services International – Tanzania) uses social marketing to promote Insecticide Treated Bednets (ITNs). Since TEHIP published the malaria map, "PSI could find out 'where' and 'when' to start promotions in the regions and the districts without having to do the research first" (#3, interview, Thursday 26 September, 2002). In addition, other donors, including PSI and the National Malaria Control Program (NMCP) are using the MARA maps in their own presentations and expressed the intention to apply the concept of mapping to other health issues and illnesses:

TEHIP has highly scientific evidence – malaria mapping, IT and computer software – malaria mapping is being used at the national level. But the idea could also be deployed for use of other things (#3, interview, Wednesday 25 September, 2002).

TEHIP staff see the potential to use these tools to guide interventions related to TB, Bilharzia and HIV/AIDS.

TEHIP's work in this area has also contributed to, and influenced, national health policies concerning ITNs:

[TEHIP] influenced certain aspects of the national health policy. One of them was the ITN (insecticide treated nets). TEHIP's work, especially in Morogoro was to assist the Ministry of Health to scale up the implementation of ITN. By scaling up I mean going at the national level... TEHIP looked at different modalities of ITN implementation within the district setting. Then they came up with a system that is deliverable – the whole system right from the procurement at the national level, pricing, what type of interface should be used (and when and how) and the challenges of delivery systems within the districts. They are also documenting the effectiveness of the ITN. This led to very convincing evidence that the Ministry of Health took up (#2, interview, Monday 7 October, 2002).

Although respondents give several different versions of the extent to which TEHIP data was directly connected with regards to changing the anti-malarial drug policy, the interviews strongly suggest that the TEHIP approach influenced the use of **research** evidence to change national drug policy. Additionally, TEHIP is helping to test different anti-malarial drugs that as this respondent notes, will have major implications for future policies on the selection of anti-malarial drugs:

Another aspect of influence at the national level: the C-T trials. We had an anti-malarial drug policy whereby we have a first line of defense, a second line and so on and so forth. The first line is SP. Together, TEHIP and AMMP, with other groups from abroad especially the US, TEHIP assisted in looking after combination therapies and the relation between reduction in morbidity and mortality by using different combination therapies. They are still ongoing, and some of the products of the work is still coming and will have major implications in terms of how the MOH will address this problem (#2, interview, Monday 7 October, 2002).

The fact that the MOH is supporting ongoing studies and research into anti-malarial treatments illustrates how the government is now shifting towards using research to generate new knowledge and evidence to establish guidelines and policies that will improve the overall health of Tanzanians.

Essential Health Minimum Package

Currently, the government of Tanzania has defined the Essential Health Minimum Package to include:

- ❑ Reproductive and Child Health (e.g., IMCI, Safe Motherhood)
- ❑ Communicable Disease Control (e.g., malaria)
- ❑ Non Communicable Disease Control (e.g., cardiovascular disease)
- ❑ Treatment of Common Disease
- ❑ Community Health (e.g., education, water and sanitation)

Recently, the central government approved nation-wide implementation of the Integrated Management of Childhood Illnesses (IMCI) as an approach and strategy to address childhood mortality. Respondents frequently cited TEHIP as being able to demonstrate the value of such interventions (e.g., IMCI and ITNs) in terms of lowering morbidity and mortality rates as well as being cost-effective. One researcher stated that “*TEHIP funding to the Districts made a very big difference; [it] enabled them to apply funding flexibly. IMCI and ITNs would not have been possible without TEHIP*”.

Using TEHIP experiences as input to their decision-making, the central Ministry of Health has thus been able to select those interventions that they define as being “essential” and which will reduce morbidity and mortality rates in a cost-effective way.

TEHIP’s Influence on the National Research System

In addition to the influence on the content and processes of national level policies, TEHIP has also contributed to strengthening the national research system. There is now widespread recognition of the value of demographic surveillance in the health and other sectors. As one respondent succinctly stated, “*together, both TEHIP and AMMP have influenced MOH to set up a NSS [National Sentinel Surveillance System]*”. This system can feed health data and other information directly to the central government that can use it to inform decisions.

Moreover, many respondents, including decision-makers, researchers and policy implementers, recognize the value of having a demographic surveillance system to provide them with information other than just health statistics. Information regarding the economy and other social sectors including education, could be very useful when, as one researcher explains, a demographic surveillance system is linked to other development processes:

TEHIP could be useful [if it was linked] to the management of the Poverty Reduction Strategy Program (PRSP). Demographic surveillance could be useful to develop an evidence-based approach for poverty-reduction intervention and monitoring (#2, interview, Monday 23 September, 2002).

Further on this idea, another respondent anticipates the use of the demographic surveillance system by other researchers to use for their own work:

At the national level, we intend to aggregate data on specific diseases. The burden of disease tool is very powerful for planning and monitoring and we hope to expand its use. The adoption of new tools happens very slowly in the MOH; having a national demographic surveillance system could be a very important resource for many sectors of development (#4b, interview, Friday 4 October, 2002).

Using an evidence-based approach for health systems planning and management that is linked to ongoing government-initiated reforms has also resulted in sensitizing government officials to the need for regular feedback. According to researchers, senior government officials now recognize the need for “*detailed, accurate data across the whole country*” which they could potentially obtain through demographic surveillance systems.

The TEHIP approach has also strengthened the capacity of national institutions such as the National Institute of Medical Research (NIMR) and the Zonal Training Centres. The TEHIP office is currently located within the National Institute of Medical Research (NIMR). According to some, the close proximity of these two research bodies has been beneficial for both, especially NIMR which is now seen as capable of conducting evidence-based research rather than focusing on bio-medical research “*maybe because of the synergy with TEHIP*”. As a result, the Ministry of Health is “*much happier with NIMR*”. One respondent directly attributed this change in attitude to TEHIP and claims that TEHIP helped by “*participating in fora and developing thinking*”.

Additionally, there is also recognition of the need to institutionalize health research information and as one researcher from Ifakara observed NIMR is now taking on that responsibility:

There is no common house to gather, synthesize and distribute health research information. MOH's Health Systems Research Unit is weak (not a very good vision; does research and training whereas it should be doing health systems analysis). NIMR now has a health systems and policy analysis unit whose mandate is (or will be) to: (1) identify where further research is needed; and (2) get accurate research information to researchers, policy makers, program implementers and the public through the mass media (#2, interview, Saturday 27 September, 2002).

The examples provided by respondents indicate that TEHIP influenced the thinking behind using health systems research information, and has contributed to building the capacity of national research institutes to conduct and promote the use of health information more effectively. There appears to be widespread recognition of the need to strengthen such systems in order to provide policy and decision makers with the evidence they need to make more informed decisions.

Chapter V

Types of Influence

Based on an adaptation of Lindquist's framework¹⁶, the influence of TEHIP on national level policy can be characterized as: (1) expanding policy capacities; (2) broadening policy horizons; and (3) affecting policy regimes. Evidence for all three types of influence were found in this case study and are presented in this section.

I. Expanding policy capacities:

(a) Conducting and creating use for policy relevant research

- ☐ The development and implementation of tools
- ☐ Results from research demonstrate that implementing essential health packages does not cost US\$12 per capita
- ☐ Roll-out/National Surveillance System intentions

Expanded policy capacities are directly related to the research conducted throughout the project. Specifically, district health managers and researchers now have the capacity to use tools that can generate complex health information in a format that is both informative and useful. Almost all respondents interviewed for this case study stated that the burden of disease and resource allocation tools developed by TEHIP were important contributions to the health sector reforms:

TEHIP has made us (MOH) aware of a lot of issues: burden of disease, allocation of resources, improving our health research facilities, and the use of evidence (#1, interview, Tuesday 24 September, 2002).

By combining the information generated by these tools, government officials in several central government departments (e.g., Ministry of Health, Ministry of Local Government) were enabled to use complex health information to make decisions regarding cost-effective health interventions at both the district and central levels.

Numerous Ministry of Health respondents also stated that because of this information they now know, from the evidence provided by TEHIP that implementing an essential health package does not cost as much as had been initially expected. Evidence from TEHIP has shown that health interventions implemented in the two TEHIP-supported districts clearly reduced mortality rates by contributing an additional US\$1 per capita per annum to health care funding. And as one respondent stated, the demonstration of this provided a channel to influence the government and for the government, "*demonstration was the biggest factor*". This evidence also persuaded the central government to consider the development of a nation-wide roll-out strategy that would make these tools available to all the districts. One element of this roll-out strategy is to build on the demographic surveillance systems developed by TEHIP and AMMP to create a national surveillance system to generate the required information for districts to use.

¹⁶ The adaptation of Lindquist's framework can be found in "Confluence and Influence: Building Policy Capacities in Research Networks" (2003). Carden, Fred and Neilson, Stephanie (publication forthcoming).

(b) Enhancing capacities of researchers to communicate knowledge and ideas to diverse audiences

- ❑ Enhancing the capacity of MOH staff to present and disseminate the TEHIP burden of disease and resource allocation tools in a manner that is easily understood to diverse audiences
- ❑ Other researchers (e.g., Ifakara) learning how to package results in a manner that is appealing to policy makers

Two members of the TEHIP team are currently on secondment from the Ministry of Health. Through their participation they have been directly engaged in the planning and implementation of the project, conducted training, and prepared and presented papers on the use of the BoD and resource allocation tools to diverse audiences locally, nationally, regionally, and internationally. The intention of using a 'counterpart' system was to increase and draw on indigenous knowledge and ownership. This evaluation did not directly assess this dimension of capacity building within the project. Casual observations by the two evaluators during the field visit suggest however, that the counterparts' capacities to communicate and disseminate these innovations were significant¹⁷.

According to one respondent, researchers used data generated through TEHIP to argue for a change in the type of anti-malarial that was at that time currently prescribed by the MOH. Working closely with TEHIP staff, these researchers learned that more than just raw data, or statistics, is needed to make an argument – you need to know how to make it appealing to policy makers. They learned how to handle the packaging of results in a way that would get the attention from policy makers.

(c) Developing new talent for research and analysis

- ❑ Building the capacity of MOH staff and district level health managers (CHMTs) to conduct burden of disease research and analysis to assist district health planning
- ❑ Working with NIMR and AMMP

Indigenous participation in this project has enhanced their capacity to undertake research and implement projects and programs that are relevant to national policy and decision makers, and local level policy implementers. By becoming skilled at developing tools for policy makers and implementers researchers are more likely to conduct practical and applied research that is relevant and useful to those who need the information. More importantly, they are increasing their skills for communicating ideas and information in a way that policy and decision makers can understand in a timely fashion.

Working with other researchers (e.g., researchers with NIMR, Ifakara and AMMP) at the national level also built their capacity to undertake policy relevant research. Although these researchers were not specifically targeted as beneficiaries of TEHIP or of the research conducted, the tools and approaches developed and implemented by the TEHIP team has resulted in building their capacity to conduct evidence-based research.

¹⁷ In the year since this fieldwork was carried out, the MOH has commissioned local experts to assist them with the national roll-out of the TEHIP tools.

II. Broadening policy Horizons:

(a) Introducing new concepts to frame debates, putting ideas on the agenda

- ❑ Matching health interventions against intervention-addressable mortality data, with district health budgets
- ❑ Evidence useful in planning and improving essential health services

The burden of disease concept is not new; however, linking the burden of disease with resource allocation data using graphics framed the debate regarding health systems planning and management at the district level in a new way. It is changing their thinking in terms of the usefulness of research and data generated:

The tools and data – the results, are changing our thinking. The tools are making things move faster in the district and they are giving the HSRs more meaning. These tools, and how they were implemented, have provided the central authority with very important lessons in terms of the value of research (#1, interview, Wednesday 2 October, 2002).

This has enabled policy and decision-makers at both the central government level and the district level to select those health services and interventions most needed. This approach has also encouraged them to use evidence-based planning in the health sector and appears to be beginning to spill-over into other social sectors (e.g., education).

The BoD tool has helped move malaria close to the top of the health agenda. The tool shows that malaria continues to be a significant burden on Tanzania's population. Previously, districts were not able to demonstrate to the central government the magnitude of the problem. As a result, district councils were not able to implement or deliver the necessary services. Now that there are tools available that illustrate the diseases and illnesses that place the highest burden on local populations, districts are able to access higher levels of funds to implement malaria interventions. Health officials within the central government are now attentive to this issue as seen in policy changes affecting malaria interventions.

(b) Making sure knowledge is available to policy makers in forms that make it possible for decision-makers and others in the policy community to use it.

- ❑ The TEHIP tools provide information in a graphical format that is both accessible and comprehensive for policy makers and implementers to use to make informed decisions regarding the selection of health services and interventions
- ❑ The tools help them generate their own knowledge

The use of computer initiated graphics to communicate the BoD and resource allocation was extremely useful for communicating very complex health economic information to policy and decision-makers in a very simple manner. The graphs generated from the BoD data clearly show which diseases are placing the highest burden on the district's population. When combined with the resource allocation data, the graphics illustrate where the mismatch between burden of disease and resource allocation lies. Central Ministry of Health respondents were exceptionally pleased with this kind of information, especially when it is displayed in a manner that is easy for them to understand. As a result, they are able to respond to these problems and issues more quickly than if they had to sift through vast amounts of highly complex health and economic data, tables, charts etc. For example, health information that is now available for policy makers was used to inform decisions regarding which health interventions to select as part of the "minimum essential package". Policy makers and implementers now have tools to assist them to examine issues concerning burden of disease, available resources and the cost-effectiveness of implementing certain interventions.

III. Affecting policy regimes:

(a) Modifying existing programs or policies

- ☐ Inputs and strategies for health sector reforms
- ☐ Input for the minimum Essential Health Package
- ☐ Simulated basket funding – same process now being used to fund health sector

The TEHIP tools, along with the TEHIP approach, have provided inputs and strategies for both Ministry of Health officials and district health officials as they implement the health sector reforms. These inputs and strategies have resulted in modifying anti-malarial policies, minimum essential health packages, as well as modifying the guidelines and health sector strategies for the next three years.

The 'basket funding' approach to the health sector budget was also directly attributed to the TEHIP approach of 'topping-up' the health sector funds. This has resulted in a new funding process for the Ministry of Health and its SWAp donor partnerships to the CHMTs.

Chapter VI

Factors of Policy Influence

There were several factors that both contributed to and constrained the influence of TEHIP to national level health policy. Some of these factors are internal to the project including: the collaborative efforts between the donors and the central government, the resources provided at the district level, working within the **existing system** rather than creating a dual or parallel system, and the range of competencies of the TEHIP staff. Other factors are external to the project such as the decentralization and health sector reform process. This nurturing political and institutional context directly supported the development and implementation of TEHIP.

Several respondents noted factors that constrained the project's influence. These included: the experimental nature of the project, weak capacity at the district level, limited dissemination of tools and findings, and the inability of TEHIP and AMMP to agree on a national demographic surveillance system.

I. Factors that Enabled Influence:

Political Commitment

The timeliness of the intervention cannot be understated. The fact that TEHIP was developed and implemented shortly after, and building on, the release of the World Development Report “*Investing in Health*” did not go unnoticed. As one respondent noted, “*the atmosphere was right for change*”. Furthermore, the Government of Tanzania submitted a proposal to the EHIP Secretariat to choose Tanzania as the testing ground for such a project, indicating high level, central support to an approach that was directed at the district level.

Respondents frequently cited that the success of TEHIP was contingent on the decentralization process already underway in Tanzania. The decentralization process meant that there was already “*commitment from top politicians*” to devolve power, authority and accountability to the districts. In other words, the political conditions were supportive of an evidence-based approach to planning at the district level:

At the start of the reform process there were a number of issues the reforms had to deal with, one of which was human capacity development. For example, the CHMTs – we needed to increase their capacity in order to implement the health system reforms...we needed an initiative to deal with this. We had a review that revealed one weakness – planning and management (#4a, interview, Friday 4 October, 2002).

The political commitment from senior level officials at both the national and district levels to support decentralization provided an “*environment that helped to make things happen*”.

Relationships between TEHIP staff and health sector officials were a strong element in the political support obtained. As one respondent explained:

*A big element of change was the appointment of a new Permanent Secretary. She is very receptive so we had an audience; we had respect...This is about **relationships**, not strategic alliances (#4b, emphasis in the original, interview, Thursday 3 October, 2002).*

TEHIP not only had a receptive target audience at high levels for their research, but that audience was able to support and enhance the profile of their research.

The Collaborative Efforts and Resources Provided

TEHIP was designed, developed and implemented as a joint initiative between the Government of Tanzania and IDRC. From the beginning, officials and representatives from the Government of Tanzania regularly attended Advisory Committee meetings, project design meetings and other important discussions. In addition, the Ministry of Health's Permanent Secretary is the Chair of the Project Steering Committee and continues to participate in TEHIP meetings on a regular basis in this capacity. Many of the respondents saw this as an important factor in its success:

The positive way in which TEHIP was received at both the central and local levels...that enabled them to function. Some of the factors that helped that reception were how TEHIP was started, that Tanzania was involved in the meetings to discuss the World Development Report (1993). This meant therefore, that there was a clear notion at the Ministry of Health level to focus on some interventions. At the district level, they received resources and resources at this level are very rare, so this helped with the reception as well. The resources were there to support the districts and this gave the people confidence (#3, interview, Monday 7 October, 2002).

TEHIP also had the money to invest in the districts. The additional resources allocated to the two TEHIP-supported districts proved to the local communities that “this was not a blah blah type of thing”. TEHIP meant business - it had the time, money, resources and competencies to contribute to the districts and local communities.

As well, TEHIP and the MOH involved community members and invited local researchers to participate throughout the implementation phase. As one respondent explained, the TEHIP process (i.e., the collaborative efforts) was important, especially when it came to designing interventions with input from the community in terms of prioritizing and implementing. The response from the community was positive and contributed to many of the changes in health service planning and delivery.

The collaborative efforts were seen by many as the way to build the confidence of the people that this project really was about benefiting Tanzania. This in turn enabled TEHIP to grow faster roots and to foster ownership by the MOH.

Working Within the Existing System

Another frequently cited comment from respondents was that TEHIP was designed and implemented with the intent to work within the existing health planning and management systems, rather than creating a parallel system. Policy makers, researchers and policy implementers all recognized the value of enhancing the capacity within the existing system in order for Tanzania's health sector to better respond and utilize the evidence brought forth from the tools being used. Below, a policy implementer at the district level gives his perspective:

*I was thinking at that time that TEHIP would be here to help us at the district especially when they said they were looking for a place they could conduct research. When they came here, though, they said no, we're not going to do the planning you are going to plan yourselves. And when the outcome of the data came out after the first year – it was beautiful...when we heard the results and that the information would be useful, that we are getting useful data that we can use for our own planning we got excited. And the most important point was that **it worked within the existing system** (#4b, emphasis in the original, interview, Monday 30 September, 2002).*

TEHIP Competencies

The personnel assembled for the TEHIP team were seen as being the appropriate ones for the task:

TEHIP has very competent people. They were already trained and ready to go to the field right away and they all had a lot of experience in this part of the world (#3, interview, Monday 7 October, 2002).

Many respondents shared this sentiment, and it was seen by many of those interviewed as a positive contribution to the project. It was also, however, seen by many as a constraint to further influence or contribution since both the Project Manager and the Research Manager were affiliated with an expatriate organization. This made it not a true test of what could be accomplished indigenously in the country. Some saw this as an additional benefit to the project and its influence since high-level officials in the MOH might be more accessible to expatriates connected to a donor agency and who are seen as “experts” in this field. These respondents hesitate to claim that the same courtesy would be extended to Tanzanian nationals.

II. Factors that Constrained Influence:

The ‘Experimental’ Nature of TEHIP

On several occasions, respondents felt that the results from TEHIP were constrained by what they referred to as the “experimental conditions” of the project:

[The] TEHIP tools were developed under “experimental conditions” in only 2 districts. Other donors were very critical at the health sector review process – there were questions of relevance to the other districts, as well as the capacity in other districts (#3, interview, Monday 7 October, 2002).

There are concerns that the technical support provided to both Rufiji and Morogoro-Rural allowed for successful results, but question whether or not such results would be replicable in other districts “without all the special attention”. Although most were of the view that the tools were replicable and could be used in other districts and even in other social sectors, many argued, “*what’s not replicable is the technical support, the monitoring, the hand-holding, etc.*” What is often left out of the added resource equation is the technical support to implement such a project. This left many feeling that TEHIP was an experiment that needs to be expanded to a few more districts before being extended on a national scale. On the other hand, one respondent expressed the view that, given its challenging conditions, “*if you can do it in Rufiji, you can do it anywhere!*”

Capacity on the Ground

The issue of capacity was also frequently mentioned as a constraint to any further influence or impact that the tools and approaches developed by TEHIP might have. Building on the notion of TEHIP as an “experiment” or “pilot project”, several respondents noted that the available capacity in the remaining 112 districts was too limited to carry on at a national level. Initially, the project also had to deal with low levels of district capacity in planning, managing and utilizing the resources:

But there are some challenges also – the capacity on the ground to plan is quite low. The districts couldn’t utilize all the resources; they couldn’t absorb them. This made it difficult to use the resources, to spend the resources, rationally. TEHIP had to struggle to build the capacity (#3, interview, Monday 7 October, 2002).

Interviewees were of the opinion that building capacity at the district level would require commitment from the Ministry of Health, and the coordinated involvement of regional officials, the Zonal Training Centres (ZTCs) and the international donors. Some were sceptical that this level of commitment and coordination could be readily achieved:

The training required to use the tools will cease once TEHIP leaves. The level of literacy in the districts is very low – this was misjudged by TEHIP. You need a certain level of investment [by MOH] to use the tools and a certain level of advocacy in order to get the MOH to implement the training and commit the resources required to do the training. They haven’t yet made this commitment (#3, interview, Wednesday 2 October, 2002).

A TEHIP staff member provided this perspective to the issue of capacity and training:

...TEHIP always worked within the context of the test districts...rather than misjudge, TEHIP recognized by bringing in certain capacity building strategies to address this and even introduced the concept of IMCI training for health workers who were not clinically trained...the training required to use the tools will not disappear when TEHIP leaves because all along the trainings have been delivered by Tanzanians or Tanzanian institutions... these will not disappear at all...sustainability was at the root of the TEHIP undertakings and not to create alternative systems... (#4b, Personal Communication, November 30, 2003).

The issue of the current level of capacity is also related to the issue of the “project trap”. Once the technical support and additional funding that is required ends, does the capacity to sustain the use of the tools and the influence on policy also end? As one respondent explained, it’s a problem with projects in general:

...the added resources and technical support – what happens when the project ends? People get paid through projects. What then? And if they move on, what about the capacity to continue?...the point is, a project has a start and an end (#3, interview, Tuesday 8 October, 2002).

By having MOH staff on the TEHIP team, by fitting within the health sector reforms and by working within the existing health services and research systems and organizations, TEHIP did much to counteract the “project trap”; however the question still remains: “Can the TEHIP tools do the same job outside of the experimental sites? Capacity is a crucial factor”.

Limited Dissemination (as seen by others)

Limited dissemination and exchange of information regarding the tools and the results was seen by some as also being a constraining factor. Health officials at both the central and district level would

liked to have seen TEHIP expose districts other than Morogoro-Rural and Rufiji to the new ideas, concepts and results. One national official stated it this way:

[If they had]...engaged the other DMOs, DEDs, and Planning Officers from the other districts we could have exposed them to the concepts and this would have been beneficial. The health sector delivery in Tanzania is no longer determined at the national level, it's determined at the district level. [TEHIP] could have shared the results with the other districts through awareness and advocacy. This is TEHIP's responsibility because the national government is already overstretched (#1, interview, Friday 27 September, 2002).

Sharing the ideas and results with the other districts, although very costly, was considered by some as an important component that was left out of the original design.

Some donors also saw limited dissemination as a problem, especially considering the potential of the use of tools and evidence by the central government:

[TEHIP] has not yet bragged to the donor community, but I think that donors would be impressed with the results. Someone from TEHIP needs to disseminate the results. They have not been vocal about the findings – they have been very discrete. But we need to see MOH as the owners of evidence and main users of evidence. I don't yet think the MOH has internalized the tools as their own (#3, interview, Tuesday 1 October, 2002).

The idea of dissemination as being an element of ownership was echoed by another donor:

The district health accounts tool was presented at the previous [health sector] review session but there was no discussion afterwards regarding how to roll-out. Now I'm wondering if the MOH doesn't have the resources to roll-out – especially technical capacity. They gave nice presentations but there hasn't been any follow-up so it's difficult to assess. There's been no information sharing. The tools could also be adapted to other sectors besides health, but for the sustainability of the tools they need a champion, an advocate (#3, interview, Monday 7 October, 2002).

Wide dissemination to a variety of audiences of the TEHIP successes was seen by some as lacking. Sustained influence needs information sharing and a strong champion to disseminate so that others can learn from the experiences. Dissemination is a critical factor that donors and recipients alike need to pay attention to when considering the sustainability of the influence and building on the experiences.

TEHIP and AMMP

Many respondents reported that there is a need to clarify and coordinate the roles and relationships of the players within the national system. And most pointed to the friction between the TEHIP and AMMP project methodologies as a case in point. Both TEHIP and now more recently, AMMP, provide demographic surveillance data to central and district level health providers. And each employs a slightly different methodology to collect this information. Some respondents suggested that the MOH had decided to use the AMMP system as the model on which to expand to a national demographic surveillance system: the NSS. Reconciling the two systems was seen as a challenge:

When MOH moves to create the NSS, all surveillance sites will be coordinated under one umbrella. This will be challenging and complex as the two main elements AMMP and RDSS started with different missions and mandates under different donors, and have developed different approaches (#2, interview, Monday 7 October, 2002).

According to respondents, there is a need to “standardize” the methods for collection of surveillance data. But this entails coordination and cooperation between TEHIP and AMMP. However, there was a lack of coordination and cooperation between the two systems:

Data from AMMP in Morogoro and RDSS in Rufiji are in conflict – they use different methods to collect and analyze data and it needs to be standardized. [We] need one system so we can apply it to all the regions (#4a, interview, Wednesday 4 October, 2002).

Many reported that the MOH should have stepped in and taken control of the situation, but felt that it did not. As a result, the friction at the project level “*had yielded very annoying arguments about the tools and approaches – without sitting down and looking for consensus solutions*”.

As summed up by one respondent, “*both AMMP and TEHIP need to pull together to make NSS happen well. There is a need to standardize the two methodologies – if not, this could damage the (future) NSS*”. From TEHIP’s perspective, these two systems are not incompatible. As explained by one staff member:

...the systems that each [TEHIP and AMMP] uses are compatible as has been demonstrated by Morogoro-Rural District receiving AMMP data but processed through the TEHIP BoD Profile tool...there is no need for the TEHIP and AMMP methods to be standardized...they can both produce valid data and information to district health planners if [the data] is processed through TEHIP’s BoD tool...there is [however], an inability by the MOH to come to terms with the existence of 2 systems and they need to play a key role and leading role in setting up a compatible NSS system... (#4b, Personal Communication, November 30, 2003).

Both systems are important generators of information. Both bring experiences and lessons to the table for MOH to consider for the NSS. Both TEHIP and AMMP have benefited and contributed to these experiences and lessons. The need now is for both systems to coordinate and cooperate in order to create a national system that provides the MOH with the evidence it needs to make informed policy decisions.

Chapter VII

TEHIP in Health Policy

I. Research to Policy Linkages in Tanzania:

National level policy and decision-makers acknowledge that research products or results are often not used when developing policies. In particular, they noted that the use of research is not strong, and that the Ministry of Health is in fact, “*not a considerable client of research studies*”. One respondent within the central government explained that research “*is not guided by demand from the Ministry [and that] even the malaria drug policy change didn’t come from the Ministry of Health – that came from the research community*”.

More specifically, a former senior Ministry of Health official reported that, “*in Tanzania, policies are not dependent on initial research. The policies are drawn from the ruling party – they are political decisions*”. This reality is not new. It is a circumstance described frequently in literature¹⁸.

Yet the environment maybe changing with the apparently wide-spread recognition that relying on evidence can increase improvements in both health status and efficiency in the use of resources. TEHIP has shown both researchers and policy makers alike that research provides valuable evidence for health planning and management at the district level:

The environment is now much better than many years ago. Now they are more interested in the findings and whether we can influence on thing or another. The environment now has potential...it’s happening in an incoherent manner, but it is somehow happening (#2, interview, Saturday 28 September, 2002).

TEHIP has also contributed to building the culture of using research-based evidence for planning:

From the work of TEHIP the MOH authorities need to learn to use research to make the right decisions and policy changes. In the primary health care system, research is a very important item. TEHIP can influence the MOH to allocate more resources to research in NIMR (#1, interview, Wednesday 2 October, 2002).

These changes appear to be occurring gradually. Changes in the behaviour of both researchers and policy makers are evident and both groups appear to be doing things a little differently from before: researchers are now conducting research based on demand, and policy and decision makers are more frequently “*coming hungry for information which would be more readily available in the West*”.

Two interviewees responded to the issue of strengthening the linkages between research and policy by creating an institution whereby evidence garnered through research would be synthesized and distributed to policy makers in an acceptable and timely format:

¹⁸ For more on the literature regarding research-policy linkages see: Neilson, S. 2001 “*Knowledge Utilization and Public Policy Processes: A Literature Review*”, Evaluation Unit, IDRC, Ottawa.

TEHIP is a rare example of the coexistence of research and intervention. This kind of operational relationship needs to continue to inform development in Tanzania. One possibility for connecting policy and research would be an institution which would synthesize and summarize research results and recommend which tools to roll-out. It would need to give research information a sense of direction and ownership, with the neutrality to make it acceptable and easier to adopt (#2, interview, Tuesday 8 October, 2002).

Other respondents, however, felt that establishing an institution such as this, although worthwhile, might be premature for Tanzania. Building on TEHIP's work – enhancing the capacity of district health officials to plan and manage health service delivery and interventions more efficiently and effectively – was a more pressing issue at this time. Another respondent felt that a **single** institution to link research to policy would be too rigid, that multiple visions were needed. He stated his point of view this way:

Influencing people with research is important but we shouldn't go with just one institution. We should have several systems to use. It would be too rigid to have one body. Let's have multiple fora. Let's get away from developing a structure for every problem. We need multiple visions and audiences and linkages (#4a, interview, Tuesday 8 October, 2002).

Reconciling these differing perspectives and points of view will not be easy for Tanzanian researchers or policy makers. But the idea that research is an effective tool to provide data and evidence to make informed decisions is gradually changing the environment for both the research and policy making communities.

II. Type and Use of Research in TEHIP:

According to Carol Weiss (1991), there are three main “types” of research: research as data, research as ideas, and research as argument. Research as data “assumes that the data or sets of findings obtained meets the users’ needs and that there is no conflict in terms of what solution, or goal, is wanted or required in order to resolve the problem”¹⁹. In other words, TEHIP did not set out to explore other options rather than decentralization policies within the health sector (i.e., research as ideas;) nor did it set out to argue that decentralization policies were either helpful or harmful to the Tanzanian population (i.e., research as argument). Succinctly stated, there was consensus regarding what the problem was and what solution was needed to resolve the problem. Using these criteria TEHIP appears to fall under “research as data”. TEHIP was deliberately and systematically designed to test a hypothesis set out in the World Development Report (1993). The outcome from this “test” is data for Tanzania’s Ministry of Health that they can use as input into their health sector reform strategies. There is consensus on the problem (lack of capacity and amount of resources required to plan, manage and deliver health services and interventions at the district level) and consensus on the solution (to build the capacity of health planners and managers at the district level to plan and manage using evidence from research). Even the underlying values are in harmony: there is consensus that using evidence-based planning and management is an effective way.

Weiss offers seven different models of “use” of research²⁰. Review of the documentation and project files revealed that the intent of TEHIP is to use research for the purpose of “problem-solving”; that is to say, “the communication of research on an agreed upon problem to the policy maker. This model implies that there is consensus between the researchers and the policy makers on the solution or end-state”²¹. As with the type of research, the use of research is also based on consensus.

¹⁹ Weiss, Carol (1991), quoted in Neilson, S. 2001: 11.

²⁰ Neilson, S. 2001:9.

²¹ Neilson, S. 2001:9

Comments from at least one respondent, however, characterized the use of TEHIP research by policy makers as “political”. In this sense, policy makers were seen as using research to justify or rationalize decisions already made:

Yes, [research] more to justify. There are a lot of other things which happen all over the world. For example, the TB initiative of WHO and they are promoting it. Then people are hearing about it and saying let's try to do that in our own country. They are expecting positive results to justify on what they want...[it's good to justify]...but...it's bad if all you want is to justify. If you have already decided to do this why not just get it implemented? Why not introduce it? (#2, interview, Saturday 28 September, 2002).

The instrumental use of research for the purpose of problem-solving fits well within the framework of “evidence-based planning”. In his article, *“Complexity, Evaluation and Evidence-Based Policy”*, Ian Sanderson argues that, on one level policy makers may refer to technical evidence and research to bolster support for the legitimization and justification of their policies, “*but use research evidence only when it supports politically-driven priorities*”²². This supports the above quote that deals with using research as a form of justification. His article also examines the work by Nutley and Webb who suggest that evidence-based policy and practice “*...fits well with a rational decision-making model of the policy process*”. He goes on to say that, “*within this rational model, then, the focus is on improving the ‘instrumental’ use of research and evaluation*”.

This type and use of research is favoured within the health sector since the research provides evidence of efficacy and effectiveness, or rather, “*which technologies or other interventions are able to bring about the desired outcomes for different patient groups*”²³. Outcomes in this sense are a reduction in morbidity and mortality, and an improvement in the quality of life.

Concurrently, the instrumental use of TEHIP's tools (i.e., technology) has also contributed to the “enlightenment” of researchers and policy makers with regards to using such research to plan and manage Tanzania's health care system at the district level. As previously reported in this study, there is evidence to support the idea that TEHIP has made significant contributions to the newly emerging culture of using research for planning purposes.

The “evidence-based” approach, however, does pose some challenges to other social sectors that tend to have more “diverse and eclectic” methodological underpinnings. Unlike health care, where the nature of outcomes and evidence is relatively undisputed, social sectors such as education and social care tend to have stronger divisions between their various methodological approaches and interventions. As a result, the nature of outcomes and evidence can be more highly contested, “*thus, knowledge of ‘what works’ tends to be influenced by the kinds of questions asked, and is in any case largely provisional and highly context dependent*”²⁴.

Using evidence to inform policy and practice is an area of considerable interest for many researchers. Nonetheless, debates pertaining to what constitutes knowledge, evidence and outcomes in specific situations are often present and may need to be resolved before evidence-based approaches can proceed effectively. As Nutley and Davis propose,

²² Sanderson, I. 2000 “Complexity, Evaluation and Evidence-Based Policy”, Policy Research Institute, Leeds Metropolitan University, UK. Paper for European Evaluation Society: Fourth Conference: Taking Evaluation to the People: Between Civil Society, Public Management and the Polity, Lausanne, Switzerland, October 12-14, 2000:3.

²³ Davies, Huw T.O., Nutley, Sandra M. 2001 “Evidence-based policy and practice: moving from rhetoric to reality”, CEM Centre, University of Durham: 87.

²⁴ Davis and Nutley. 2001:87.

...observations suggest that if we are indeed interested in developing an agenda where evidence is more influential, then first of all we need to develop some agreement as to what constitutes evidence, in what context, for addressing different types of policy/practice questions. This involves being more explicit about the role of research vis-à-vis other sources of information, as well as greater clarity about the relative strengths and weaknesses of different methodological stances²⁵.

What constitutes evidence and how it is used in an evidence-based planning approach was also a concern for one member of the former EHIP International Advisory Committee:

Ms Aidoo was concerned that the project ensures that the evidence used is not merely that which is easily observable or statistical in nature – researchers must indicate cultural sensitivity in the design of their instruments. For example, it can be difficult to obtain useful information on issues relating to female reproductive health²⁶.

Being explicit about what constitutes evidence, how the evidence is collected and the context in which the research is taking place is an important area for discussion for development agencies and research institutions that undertake and/or fund research for development projects.

²⁵ Davis and Nutley. 2001: 88

²⁶ Final Minutes, September 13, 1997. EHIP IAC Minutes from Meeting 18 April, 1997, Dar es Salaam, Tanzania.

Concluding Remarks

The Challenge to Sustaining the TEHIP Influence:

The challenges for the TEHIP-developed tools and the implementation process are numerous. Among other things, this case study illustrates the paradoxical nature of “successful projects: then what?” How much does a very successful project tell policy and decision makers about expanding the success to a larger population through necessarily different mechanisms? With its added technical and financial contributions into the local infrastructure and capacity, the TEHIP experience was seen by many as an experiment that is not replicable within the existing resource levels across the country. What was also revealed was an issue of ownership: the Ministry of Health does not appear to be acting as if the tools were their own to use and expand throughout other districts.

By far the most frequently cited issue with regards to sustaining TEHIP, and its influence on policy, was how to expand externally funded, district-level projects to a national scale? (See Box 2). Many constraints were brought out during the interviews including the cost of expansion, the lack of capacity to replicate, and the technical support required to implement the tools in the remaining 112 districts. By and large, respondents who held this view would agree with this district level official who stated, “*the districts can’t support TEHIP activities 100% once TEHIP ends*”. As one TEHIP staff member pointed out, additional resources were essential to develop the tools, but since the tools exist now, additional resources for tool development are not required (#4b, Personal Communication, November 30, 2003). What remains to be determined, however, is the level of support and resources needed for a national level roll-out and training.

The added resources, especially the technical assistance, was seen as one of the main constraints or challenges to expanding TEHIP on a national scale:

Expanding to the national scale, there isn’t the technical support that was available for the two TEHIP districts. What is the minimum package of technical support necessary for all districts? And, given that feedback capacity at the district level is weak, how will the quality of services be monitored? (#3, interview, Tuesday 8 October, 2002.)

Respondents also emphasized a second major constraint to a full roll-out: a lack of coordination among the various players working in the health sector. Without more effective coordination and cooperation among donors, health care workers and training centres, “*confusion and competition will exist*”. While most respondents agree that there needs to be an articulated process for the roll-out, they expressed a range of views as to what roles the various actors should have. Different donors support different districts, which are developing their own approaches to planning. This posits the question: which tools do we use? As one respondent stated, “*what we need now is a coordinated roll-out of existing, proven initiatives*”.

Box2: The Challenge of Translating TEHIP to a National Scale

How do you translate the success of the national change in the districts? In one district it is manageable to have to go from research to planning but then translate to national policy – how does one do that? It’s been discussed at the Annual Health Review to have the TEHIP model translated into a national strategy for planning at the district level; the difficulty is how to do you go from the district-based approach to national policy for all 114 districts. Different donors support the districts; therefore, the districts have different tools and approaches to planning – which one is the best one and what are you going to do? The point is, what happens in the district when you stop the TEHIP support to the district and make it national policy? Then you give in on quality in order to go mainstream...as soon as the technical support of the district gets out you give in on quality because then the same people have to do the same job without the technical support. I haven’t seen any successes on that one...what is the minimum TEHIP package which should be taken over or be translated into national policy for the health sector reform? I think malaria is the best example, because here is where you see your success (#3, interview, Tuesday 8 October, 2002).

The MOH will need to confront these challenges in order to sustain and expand the use of the tools and influence that TEHIP has produced²⁷.

²⁷ A recent TEHIP perspective is more cautiously optimistic: "...the regional roll-out is being tackled and it does not require the whole TEHIP team to be sitting in Dar es Salaam but can rely on Tanzanian leadership and institutions to tackle this problem and TEHIP is helping the MOH to improve its national training machinery which will make the task even easier!" (#4b, Personal Communication, November 30, 2003).

Appendix 1: Terms of Reference

A. Background

Many IDRC project and program objectives reflect the expectation that the research supported will influence public policy at the national and local levels. Within projects and programs, Centre staff promote various means of linking research to public policy, and research supported is often reported to have enhanced decision makers' awareness of policy options or to have been otherwise taken into account in policy processes. If the Centre is going to increase (and improve the performance of) its portfolio of projects with this mandate, the Centre needs to address what it means by "policy influence". Initial discussions with Centre staff, and reviews of the literature and other relevant Centre documents point to three key questions: (1) what constitutes public policy influence in IDRC's experience; (2) to what degrees, and in what ways, has IDRC-supported research influenced public policy; and (3) what factors and conditions have facilitated or inhibited the public policy influence potential of IDRC-supported research. This will serve two main purposes: first, it will provide learning at the program level which can enhance the design of projects and programs to address policy issues where that is a key objective; second, it will provide an opportunity for corporate level learning which will provide input to the strategic planning process, providing feedback on performance, and feeding the design of the next corporate program framework.

The cases studies will form one important set of data in improving the Centre's capacity to support research which *"will foster and support the production, dissemination and application of research results leading to policies and technologies that enhance the lives of people in developing countries"* (IDRC program directions 2000-2005, p.16). Attached are three documents which provide the background to the overall study: (1) Study Overview; (2) Framework Paper by E. Lindquist; and (3) Literature Review by S. Neilson.

The focus of case studies will be on the development of rich case studies that explore not only the IDRC work undertaken but also the changing context in which the work was carried out and the processes that were used. It is anticipated that the study will cover a range of stories to include cases where policy outcomes may be perceived as either positive or negative (i.e., research leads to "good" policymaking or "bad" policymaking). The cases will present detailed stories of the policy influence process. The story will be developed through: (1) A review of documents including project design documents, monitoring documents (i.e., technical reports, trip reports, correspondence) and project reports; and where they can be located; (2) Interviews with project leaders and project participants; (3) Interviews with those said to have been influenced; and (4) Interviews with relevant IDRC staff (e.g. responsible PO's).

B. TORs

In order to prepare the case study, the consultant is expected to have reviewed project documents prior to any interviews and to know the role of the interviewee in the project. Interviews should normally move out from those most directly affiliated with the project to those purported to have been affected by or to have used the results in some way. Because there is inherent bias in interviewees to present findings in the best possible light, triangulation of data sources is crucial. Every effort should be made to ensure that interviews are conducted with representatives of at least three of the main groups involved: project implementers, beneficiaries, POs, policy makers and where applicable related project participants (other funded or departmental studies which have been linked to the project). The consultant will normally have an opportunity for follow-up visits for data verification or further data collection where warranted.

The consultant will collect data in three key areas:

1. What led to the project:

– How did you get involved in [area of exploration] in the first place?

This has to do with clarifying the role of the interviewee as a leader, a respondent to an issue that was raised, as someone who has seen this field for a long time, as a policy maker, researcher, funder, etc. In the case of interviewing a PO, this might be expressed in terms of response to a proposal, in terms of project development with regards to how policy influence may or may not have been incorporated into the proposal, in terms of their leadership in a research field; in the case of a researcher, this might be raised in terms of a problematique in their country, in terms of fall-out of their previous research, in terms of a dialogue with a PO, in terms of a proposal they have been floating for a long time seeking funding, etc. In the case of a purported beneficiary, their involvement might be much later in hearing the results and connecting them with an issue in their Ministry, Department or Organization.

2. About the project:

– When it was started, what did [the project] intend to achieve?

Here one knows the objectives already, it is a discussion starter with the interviewee; they can be prompted as appropriate with the project objectives. One should identify the nature of the project as characterized by the interview, in terms of capacity building objectives, the policy influence objectives if any, the overall intent of the activity. This should also include the researcher's understanding of policy influence in terms what that means, what that entails (assumptions, hypotheses re: influencing policy). If any areas of objectives are left out, the interviewer should introduce them.

– What happened?

What was accomplished (were project objectives met, changed, completely revised, not met, but good things happened, not met but bad things happened; nothing happened, etc.) Here the interviewer is expected to move the interview towards policy related influence, but without closing off areas of activity that might have led to policy influence later. Where there is policy influence identified (as there should be in all cases), the interviewer needs to probe who was influenced, including their positions at the time of influence and their current positions if known, and in what ways. This could include (but is not limited to) the following:

People inside the policy process:

- (1) Policy workers (those in the front line of policy recommendation and development)
- (2) Policy decision makers (those in charge of policy decisions: political and bureaucratic)

People outside the policy process:

- (1) Those who directly influence policy makers
- (2) Those who indirectly influence policy makers

The interviewee should give an indication of what indicators they are using to determine if there has been policy influence and how they define it. This will be a crucial data set in defining policy influence. Types of policy influence (after Lindquist) include (but are not limited to):

Expanding policy capacities:

- Improving the knowledge / data of certain actors
- Supporting recipients to develop innovative ideas
- Improving capabilities to communicate ideas
- Developing new talent for research and analysis

Broadening of policy horizons:

- Providing opportunities for networking / learning within the jurisdiction or with colleagues elsewhere
- Introducing new concepts to frame debates, putting ideas on the agenda, or stimulating public debate
- Educating researchers and others who take up new positions with broader understanding of issues
- Stimulating quiet dialogue among decision makers and among or with researchers—

Affecting policy regimes

Modification of existing programs or policies
 Fundamental re-design of programs and policies

The consultant will identify behavioural change associated with these three types of influence and any additional types of influence that do not appear to fit this categorization will also be named.

Capacity building is a critical dimension of policy influence. By capacity building, we refer to the process by which individuals, groups, organizations and institutions strengthen their ability to carry out their functions and achieve the desired results over time (Peter Morgan 1997). This refers therefore to the capabilities of individuals, organizations, institutions, and to the strengthening of relationships among them.

– Why did it happen?

This is crucial as it deals with the relationship between the context and the project. Type of governance regime in the country is a critical factor for consideration. Perceptions about why should vary among interviewees and the discussion will build from interview to interview on a project. What were the contextual factors and what were the capacity factors within the project team? What favoured/inhibited progress? Who did what? Here, one should be identifying the key influences both within the project and in its enabling environment that caused the project to develop as it did. Dissemination strategies should also be explored.

3. What happened after the project:

Depending on the age of the project, it is crucial here to explore what is perceived to have been influenced by the project, when that influence occurred and whether or not the policy change or change in mind set (if any type of change actually happened) endured.

Here it is important to come back to outcomes and outputs of the project which may have appeared to have no policy linkage during the time of the project, but which may have had some later.

External factors are key to consider here: what changed, what remained constant in the political, legislative, economic, technical and social environments related to the project's work?

Tracing organizations and individual project members is critical: where did they go? What did they go on to do?

Tracing beneficiaries is also key: what was their role in sustaining the change (if any); what was their role in introducing new changes? Where did they go and what did they go on to do?

We are particularly interested in the role of the PO and IDRC generally in these processes: what is the perceived role (by project participants, by beneficiaries, by other related individuals and groups)? Dissemination strategies should be reviewed.

C. Gender

Gender dimensions are discussed here, but relate to all stages of the activity - planning, implementation and post project. Gender should be considered with regards to tracing of project implementation team members as well as beneficiaries: were both men and women involved in the policy influence process and in what ways? How was this perceived by policy makers and by researchers (contributing inhibiting, neutral factor)? Was analysis gender sensitive or gender neutral at all stage of the policy influence process? -

- Problem definition
- Definition of goals and beneficiaries
- Definition of research agenda
- Definition of research policy interface and linkages
- Formulation of policy options
- Choice of preferred options
- (Where applicable, implementation, M&E, policy revision processes)

Each area should cover the opening question first, followed by questions and discussions to elicit information related to the three main questions of the study

C. Tombstone Data

In addition to the case elements outlined, for purposes of data analysis, the consultant will include in each case the following information (items 1*-7* to be provided by the Centre):

1. Project name*
2. Project Number*
3. Dollar value*
4. Project start date (right term?)*
5. Project duration (until legal Closure)*
6. Name of recipient institution(s)*
7. CAP/RAP break (Centre-administered portion of funds, vs recipient administered portion of funds)*
8. Intent of policy influence: while it may be clear from the objectives whether or not policy influence was intended in a given activity, other aspects of the project document may require review in order to determine the intent vis-à-vis policy influence.
9. Type of project recipient:
 - Research Centre
 - University
 - NGO
 - INGO
 - Government Department
 - a. International
 - b. National
 - c. Provincial
 - d. Local
 - Government Specialized agency
 - a. International
 - b. National
 - c. Provincial
 - d. Local
 - UN agency
 - Other multilateral agency
 - Consultant (individual or organization)

10. Type of project beneficiary identified (if not same as recipient):
 - Research Centre
 - University
 - NGO
 - INGO
 - Government Department
 - Government Specialized agency
 - UN agency
 - Other multilateral agency
 - Consultant (individual or organization)

11. Type of use identified for the research (per Carol Weiss):
 - Problem solving
 - Knowledge generation
 - Enlightenment
 - Political
 - Tactical
 - Interactive
 - Intellectual

12. Policy area (wide open category in terms of what area of policy is intended to or is influenced), e.g., – policies for ICTs in schools

D. Process

The consultant will participate in a meeting with the evaluation unit and other consultants on the study. The purpose of the meeting is to: consult about the TORs and ensure as much consistency as possible across sites; and present the consultants with the view of the project as a whole and the role of the case studies in the evaluation.

On completion and write up of the case study, the consultant will, at the invitation of the Centre, participate in a regional-level analysis of the cases in the region. Other participants would include other consultants, some of the project leaders (possibly from the studies involved, or other related projects in the region), regional POs, RD, 1 or 2 “experts” from the region, and a member of the evaluation team.

The consultant will make a brief presentation, describing the case and indicating preliminary findings. The consultant may be asked to facilitate the data analysis or may be asked to be an active participant in the process.

Following the workshops, the team may determine that it is advantageous to follow up the findings with further data collection in the field, either for the introduction of new respondents or to gather data in areas not yet addressed in the case.

Upon completion of the case studies, and the development of a regional analysis, the Unit may invite the consultant to participate in a preliminary global analysis of the data. On the basis of these documents, the consultants will be reconvened with the evaluation team for further analysis of the findings.

E. Products

The consultant will work with the Centre to identify and locate the appropriate individuals to be interviewed. The consultant may also have to search out individuals who are no longer known to the Centre but who were central to the project.

Based on the TORs and reading the project file, the consultant will develop interview guides for interviews with project leaders and participants, program officers, beneficiaries and others reached in the implementation and follow up to the project. These interview guides will be shared with and approved by the Centre.

The consultant will submit trip reports for all travel related to the project. These trip reports should include the names and coordinates of all interviewees as well as any preliminary findings which might be of relevance to other consultants carrying out case work elsewhere.

The consultant will submit copies of all interviews conducted as they are written up. The consultant will provide a draft report to the Centre for its comment.

Based on feedback, the consultant will revise the report for use at a regional or Ottawa consultation.

Based on the findings of the consultation, further revisions will be incorporated into a final report.

References:

Peter Morgan, 1997. *The design and use of capacity development indicators*. Paper prepared for CIDA.

Appendix 2: List of Interview Questions

- (1) What happened after the project?
 - What has happened since the project was completed? What are you doing now?
 - What dissemination activity continued?
 - Who used the research (same people or new additions)?
 - If they have left the orbit of the project, where are involved researchers and policy makers now? (*Probe – Where are they? What are they doing?*)
 - If they are still involved with the project or its research findings and recommendations, what role are they playing and what actions are they taking?
 - What additional change has occurred?
- (2) What led to the project?
 - How did you get involved?
 - What was your role?
 - What was the issue or condition you were trying to address? (**Gender probe** – *were there gender considerations and what were they?*)
 - Who were the other key players in your view? **Gender probe** – *be specific about who the key players are, what role they played in order to determine the type and/or level of involvement, engagement, participation of the various actors and to examine if there are any differences between the level and/or type of involvement by men and women (also, which women needs to be considered – local community members, national level politicians etc.)*
 - Who makes policy – e.g. which individuals or groups? (**Probe for researchers and IDRC staff, Program Officers** - *Try to get at their understanding of “good” vs “bad” policy making as one of the elements*). **Gender probe** – *specifically, who is involved at this level; how would you characterize their involvement?; to ensure different perspectives are heard and retained at higher levels, it is important to consider such questions as: Who records proceedings and checks conclusions? Who writes reports and edits any plans? To whom are decision makers accountable? Who monitors their accountability?*
 - Did the project team (including the IDRC officer involved) discuss policy influence and was this incorporated into the proposal? (*Alternative question – In terms of your understanding of the process of research influencing policy: where does this project fit in that process?*)
 - Were there any constraints or barriers when developing this project? If so, what were they?
- (3) What happened during the project?
 - When it started, what did the project intend to achieve? (*Probe in relation to project documentation*)
 - What happened? (Outputs, constraints, approach)
 - Where the objectives met, revised, changed, dropped, added?
 - What dissemination strategies were used and to what effect? (**Gender probe** – *were different dissemination strategies used for men and women? Why/ why not?*)
 - Who was influenced?

People inside the policy process – who and in what ways?

- Policy workers (those in the front line of policy recommendations and development; **gender probe** – *advocacy/lobby groups?; Who/what organization?; Do they have “hearing”? what role do they play?*)
- Policy decision makers (in charge of policy decisions: political and bureaucratic; **gender probe** – *be specific about who, what role they play etc.*)

People outside the policy process – who and in what ways? (**Gender probe** – *for both actors in question be as specific as possible in terms of who, what role they play etc.*)

- Those who directly influence policy makers
- Those who indirectly influence policy makers

- Who used the research? In what ways? (**Gender probe** – be specific about “who” and “what”; men and women may not use research because one of the other did not find it useful; or they may use it for different reasons or purposes)
- Now that the project is completed, what do policy makers know or do now that they did not know or do before? How do you know that? (Identify the type of policy influence you would call this from Appendix 1)
- What do researchers know or do now that they did not know or do before? How do you know that? (**Identify the type of policy influence you would call this from Appendix 1**)
- What does IDRC (POs) now know or do that they did not know or do before? (**Identify the type of policy influence you would call this from Appendix 1**)
- Why did it happen?
- What changed, or remained constant during the project in terms of the project’s environment (political, legislative, economic, technical, social)?

Types of Policy Influence -

1. Expanding policy capacities

- *Improving the knowledge / data of certain actors*
- *Supporting recipients to develop innovative ideas*
- *Improving capabilities to communicate ideas*
- *Developing new talent for research and analysis*

2. Broadening policy horizons

- *Providing opportunities for networking / learning within the jurisdiction or with colleagues elsewhere*
- *Introducing new concepts to frame debates, putting ideas on the agenda, or stimulating public debate*
- *Educating researchers and others who take up new positions with broader understanding of issues*
- *Stimulating quiet dialogue among decision makers and among or with researchers*

3. Affecting policy regimes

- *Modification of existing programs or policies*
- *Fundamental re-design of programs and policies*

Gender

Gender dimensions run throughout the questions. Key prompts need to be added so that the interviewer can provide an assessment on each of the points below as to the degree of incorporation of gender sensitive analysis.

Was analysis gender sensitive or gender neutral in the policy influence process in the following domains (indicate evidence):

- Problem definition
- Definition of goals and beneficiaries
- Definition of research agenda
- Definition of research-policy interface and linkages
- Formulation of policy options
- Choice of preferred options
- (Where applicable, implementation, M&E, policy revision processes)

Appendix 3: List of Interviewees:

- (1) Ms M Msaffisi
Permanent Secretary
Ministry of Health
PO Box 9083
Dar es Salaam
- (2) Dr G Upunda
Chief Medical Officer
Ministry of Health
PO Box 9083
Dar es Salaam
Tel: 0744 222 268
- (3) Dr A Mzige
Director, Preventive Services
Ministry of Health
PO Box 9083
Dar es Salaam
Cell: 0741 410 531
- (4) Mr E Manumbu
Director, Policy and Planning
Ministry of Health
PO Box 9083
Dar es Salaam
- (5) Dr A Hignora
Health Sector Reform Secretariat
Ministry of Health
PO Box 9083
Dar es Salaam
Tel: 0744 222 261
- (6) Dr SK Pemba
Ag Director, Human Resources Development
Ministry of Health
PO Box 9083
Dar es Salaam
Email: spemba@moh.go.tz
- (7) Dr Mohammed Amri
Disease Prevention and Control Officer
World Health Organization (WHO)
Luthuli Road
PO Box 9292
Dar es Salaam
Email: amri@who.or.tz
- (8) Dr Theopista John
National Program Officer IMIC/RH
World Health Organization (WHO)
Luthuli Road
PO Box 9292

- Dar es Salaam
Email: theo@who.or.tz
- (9) Dr M Meshak
UCLAS
PO Box 35176
Dar es Salaam
Cell: 0741 240 261
- (10) Dr A Kitua
National Medical Research Institute (NIMR)
PO Box 9653
Dar es Salaam
Email: nimr@costech.gn.org
- (11) Mr F Schleimann
Regional Technical Advisory (Health)
Danish Embassy
Ghana Avenue
PO Box 9171
Dar es Salaam
Tel: 2113887 / 0744 784424
Email: finn.s@inet.uni2.dk
- (12) Dr A Kimambo
Tanzania Public Health Association (TPHA)
PO Box 7785
Dar es Salaam
Tel: 2131441
Email: tpha@muchas.ac.tz
- (13) Dr WC Mwambazi
Country Representative
World Health Organization (WHO)
Luthuli Road
PO Box 9292
Dar es Salaam
Tel: 2113005 / 2111718
Email: mwambazi@who.or.tz
- (14) Dr J Miller
ITN Director
PSI – Tanzania
TEXCO Building
4th Floor, Pamba Road
PO Box 33500
Dar es Salaam
Tel: 2117879 / 2117372 / 2116312
Email: jemiller@twiga.com

-
- (15) Dr A Mwakilasa
Head, Continuing Education Programs
Ministry of Health
PO Box 9083
Dar es Salaam
Tel: 2137496
Email: amwakilasa@moh.go.tz
- (16) Mr M Mapunda
Coordinator, Health Sector Basket Funding
Ministry of Health
PO Box 9083
Dar es Salaam
Tel: 0741 326 378
- (17) Ms L Loughran
Health Officer
USAID
P.O. Box 9130
Dar es Salaam
Tel: 217537
- (18) Dr R Poutiainen
Head, Health Unit
UNICEF
PO Box 4076
Dar es Salaam
Tel: 2150811 / 15
- (19) Ms S. Sijaona
Permanent Secretary
Ministry of Land and Human Settlement Development
PO Box 9132
Dar es Salaam
Tel: 2113165
Fax: 2124576
- (20) Dr I Semali
Institute of Public Health
Muhimbili University College of Health Sciences (MUCHS)
P.O. Box 65001
Dar es Salaam
- (21) Dr. El Malangalila
World Bank
PO Box 2054
Dar es Salaam
Tel: 2114575

-
- (22) Dr D Mtasiwa
City/Regional Medical Officer of Health
City Commission
P.O. Box 63320
Dar es Salaam
Tel: 2112535
- (23) Dr. A Chiduo
Former Minister of Health
P.O. Box 34224
Dar es Salaam
Tel: 2630637
Mobile: 0748 668 668
- (24) Dr P Kamuzora
Institute of Development Studies, University of Dar es Salaam
P.O. Box 35169
Dar es Salaam
- (25) Dr A Mwita
National Malaria Control Programme
P.O. Box 9083
Dar es Salaam
Tel: 0741 339 713
- (26) Dr R. Mandike
National Malaria Control Programme
P.O. Box 9083
Dar es Salaam
Tel: 0744 295 323
- (27) Dr A Unwin
Ministry of Health/National Malaria Control Programme
P.O. Box 9083
Dar es Salaam
- (28) Dr. Y Ipuge
Head, Diagnostic Services; Coordinator, Hospital Reforms; National Coordinator, PMTCT
Ministry Of Health
PO Box 9083
Dar es Salaam
Tel: 0748 264 219
- (29) Mr Paul Smithson
Head, Health
DFID (British High Commission)
P.O. Box 9200
Dar es Salaam

-
- (30) Dr C Kibassa
National IMCI Coordinator
Family Planning Unit
Ministry of Health
PO Box 9083
Dar es Salaam
Tel: 2152976/7/8
Mobile: 0744 270 741
- (31) Mr. F. Fissoo
District Executive Director (DED)
P.O. Box 43
Utete, Rufiji District
- (32) Dr S. Mkikma
District Medical Officer (DMO)
P.O. Box 22
Utete, Rufiji District
- (33) Dr E Mwagemi
TEHIP
Field Station Manager, RDSS
P.O. Box 40
Ikwiriri, Rufiji District
- (34) Dr I Mwinge
Medical Officer, I/C Hospital
Council Health Management Team (CHMT)
P.O. Box 22
Utete, Rufiji District
- (35) Mr. W Mapuga
District AIDS Control Coordinator
Council Health Management Team (CHMT)
P.O. Box 22
Utete, Rufiji District
- (36) Mr. IM Mtitu
ITNS Coordinator
Council Health Management Team (CHMT)
P.O. Box 22
Utete, Rufiji District
- (37) Dr D de Savigny
Research Manager
TEHIP
Luthuli Road
PO Box 78487
Dar es Salaam
Tel: 2130627

-
- (38) Dr G Reid
Project Manager
TEHIP
Luthuli Road
PO Box 78487
Dar es Salaam
Tel: 2130627
- (39) Dr Conrad Mbuya
Country Research Coordinator
TEHIP
Luthuli Road
PO Box 78487
Dar es Salaam
Tel: 2130627
- (40) Dr Harun Kasale
Country Project Coordinator
TEHIP
Luthuli Road
PO Box 78487
Dar es Salaam
Tel: 2130627
- (41) Dr B.T. Ndawi
Director
PHC Institute - Zonal Training Centre (Iringa)
P.O. Box 235
Iringa
- (42) Dr Machibiyi
District Medical Officer (DMO)
Morogoro (Rural)
P.O. Box 1862
Morogoro
- (43) Dr H Kitange
Coordinator – NSS
Morogoro (Rural)
P.O. Box 1862
Morogoro
- (44) Dr P Kilima
Regional Coordinator, Anglophone Africa
International Trachoma Initiative (ITI)
7th Floor, NSSF Building
Morogoro Road
PO Box 78834
Dar es Salaam

-
- (45) Ms J Mahon
Health Advisor
SDC
79 Kinondoni Road
PO Box 23371
Dar es Salaam
Tel: 2666220
- (46) Mr A Buluba
Senior Program Officer (Health)
SDC
79 Kinondoni Road
PO Box 23371
Dar es Salaam
Tel: 2666220
- (47) Dr Y Hemed
Adult Morbidity and Mortality Project
P.O. Box 65243
Tel: 2153388
- (48) Mr A Kabgire
Program Manager
Local Government Reform Program
120 Kilimani Road (Kinondoni)
PO Box 105081
Dar es Salaam
Tel: 2666524
- (49) Dr S Ndeki
Principal
Centre for Educational Development in Health – CEDHA (Arusha)
PO Box 1162
Arusha
Tel: 0741 510919
- (50) Dr Z Premji
Muhimbili University College of Health Sciences (MUCHS)
PO Box 9372
Dar es Salaam
Tel: 2153419
- (51) Dr F Njau
Head, Health Sector Reform Secretariat
Ministry of Health
PO Box 9083
Dar es Salaam
Tel: 2120624
- (52) Ms D Timmermans
First Secretary Health, HIV/AIDS, Water and Sanitation
Royal Netherlands Embassy
P.O. Box 9534
Dar es Salaam

- (53) Dr H Mshinda
Director,
Ifakara Health Research & Development Centre
P.O. Box 53
Ifakara

Appendix 4: Tombstone Data

Project Name: Tanzania Essential Health Interventions Project	
Project Number: 001047	Country: Tanzania
Date Approved: 16 March 1994 Commencement: 1996 Duration: 10 years (from approval to completion) Completion Date: 2004	\$Value: 21,426,687* (total) 6,311,007* (IDRC contribution) CAP funding *Total amount appropriated as of Dec 2003
Recipient Institutions: (1) Ministry of Health; (2) Ifakara Health Research & Development Centre Institute of Development Studies	Recipient Types: (1) Government ministry; (2) research institution
Beneficiary Institutions:	Type:
Policy Target: District Council (District level authorities)	Type: local level authorities
Intent of Influence: Bring about changes at the district level; also a recognition that to bring about these changes will need to influence health policies at national level.	Source: Project documents (meeting minutes; Project Summary, 1994).
Use Identified: Type of research identified as research as data; use of research identified as "problem-solving".	Policy Domain: health

References

Carden, Fred and Neilson, Stephanie. (2003) *“Confluence and Influence: Building Policy Capacities in Research Networks”* (publication forthcoming), Evaluation Unit, IDRC, Ottawa, Canada.

Davies, Huw T.O., Nutley Sandra M. (2001) *“Evidence-based policy and practice: moving from rhetoric to reality”*, CEM Center, University of Durham.

Government of Tanzania. (2002) *“Inputs to Develop a Program of Work 1999/2000 – 2001/2002 and Action Plan 1999/2000. Draft 1, September 2002”*, Ministry of Health, Government of Tanzania, Dar es Salaam, Tanzania.

IDRC. (1996) *“Trip Report by J. Finlay: Dar es Salaam and Boston, April 15-19, 1996”*, IDRC, Ottawa, Canada. (Files available in Ottawa).

IDRC. (1997) *“Minutes (Final Version) EHIP IAC Minutes, April 18, 1997”*, September 13, 1997, Dar es Salaam, Tanzania. (Files available in Ottawa).

IDRC. (4 July 1996) *“Minutes of the EHIP IAC Meeting – 18 May 1996 (Geneva)”*, IDRC, Dar es Salaam, Tanzania. (Files available in Ottawa).

IDRC. (December 1995) *“Minutes (Final Version): EHIP Steering Committee, Dar es Salaam, 5-6 October 1994”*, IDRC, Dar es Salaam, Tanzania. (Files available in Ottawa).

IDRC. (June 1996) *“TEHIP Project Document”*, IDRC Ottawa, Canada.

Lindquist, Evert. (2001) *“Discerning Policy Influence: Framework for a Strategic Evaluation of IDRC-Supported Research”*, IDRC Ottawa, Canada. Available at:
http://web.idrc.ca/file_download.php/discerning_policy.pdf?URL_ID=12177&filename=10359907080discerning_policy.pdf&filetype=application%2Fpdf&filesize=205144&name=discerning_policy.pdf&location=user-S/

Neilson, Stephanie. (2001) *“Knowledge Utilization and Public Policy Processes: A Literature Review”*, Evaluation Unit, IDRC, Ottawa, Canada.

Sanderson, Ian. (2000) *“Complexity, Evaluation and Evidence-Based Policy”*, Policy Research Institute, Leeds Metropolitan University, UK. Paper for the European Evaluation Society: Fourth Conference: Taking Evaluation to the People: Between Civil Society, Public Management and the Polity, Lausanne, Switzerland, October 12-14, 2003.